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Tuberculosis in Nurses

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*A Study of the Disease in Sixty Nurses Admitted to the Manitoba Sanatorium**

This paper is based on a study of tuberculosis in sixty nurses or nurses-in-training who have been admitted to, or examined at, the Sanatorium within the last five years. Throughout this paper the term "nurse" includes undergraduates, and indeed any who have taken any part of the regular training of nurses. Of these all but a few came direct from their hospitals to the Sanatorium. The writer saw and treated fifty, but had to rely upon the history and records of the Sanatorium and the personal knowledge of others for the remaining ten. Since the list of sixty was closed for purposes of study, and before this paper was complete, four more nurses might have been added to the list of those admitted within the five years.

At present there are ten nurses in this Sanatorium as patients, and at one time there were as many as seventeen, or about twelve per cent of the total number of female patients. If the number of female patients in the Sanatorium can be considered as any indication of the number of tuberculous women in the Province, from seven to twelve per cent represents a high average for women of one age group. There are usually as many nurses in the Sanatorium under treatment at any one time as school teachers, stenographers and university women taken together.

A preliminary study of tuberculosis in nurses was made in this Sanatorium in 1926, and data were collected from thirteen Canadian sanatoria. A total of 1,514 women had been treated in these thirteen sanatoria, of whom 99 were nurses, a little over six and a half per cent. Fifty-two of these were graduates and forty-seven undergraduates. The facts and opinions gathered in that series will be referred to in appropriate places throughout this paper, and used in drawing conclusions. A few cases are common to both series.

Of the series of sixty, forty broke down before graduation and twenty after graduation. Ten of the graduates developed symptoms within one year of graduation, five within three years, and the remainder within from five to seventeen years. Fifty of the sixty developed tuberculosis during training or within a year afterwards.

During such a four-year period, about 800 nurses were trained and graduated in this Province. About six per cent. of these became Sanatorium patients directly from their training schools or within a year after leaving them. At this rate, then, one out of every seventeen young women entering upon training as nurses can be expected to develop tuberculosis. This appears far more striking when it is considered that in the twenty years following training there were three or four thousand graduates in the Province, and only ten of these, or about a third of one per cent, became patients in the Sanatorium. However, this is not a fair comparison because nurses in hospitals are more conveniently examined, and among any group of women the incidence of tuberculosis is higher in the younger age group. Nevertheless, all data we have go to show that tuberculosis is relatively much more common among nurses in hospitals than nurses out of hospitals; it is more common among young nurses than older graduates, and would seem to be more common among nurses than among women in general.

The sixty nurses of this series came from twenty hospitals, all but five being hospitals in Manitoba. Six nurses were admitted who were training in or had trained in hospitals outside this Province, but all had their

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(*Canadian Tuberculosis Association Prize Essay, 1929.)

homes within it. Fifty-four nurses came from fifteen Manitoba hospitals. All the larger hospitals are represented and several of the smaller. This list might be considered fairly inclusive for nurses breaking down with tuberculosis in this Province during the past five years. The numbers of nurses per hospitals were as follows: one sent eighteen, another eight, three sent four each, one sent three, four sent two each, and the remaining hospitals sent one each. The numbers who came in from the different hospitals are fairly well in proportion to the number of nurses trained in these hospitals. From this Sanatorium itself four were admitted. Three of these had pleurisy only, which cleared up completely, and one of these belonged to a heavily infected family. The only one who had a definite lung lesion came to the Sanatorium a comparatively short time after her mother's death from tuberculosis, and had a sister, not at the Sanatorium, who developed tuberculosis about the same time. It is interesting to note that from one general hospital during 1925 there were two nurses, during 1926 two, during 1927 one, and during 1928 six, four within two months. From another general hospital there were three within three months and none for many months before or after. From two other general hospitals there were two each in the same month. This may indicate that each case found increased the enthusiasm in diagnosis, but it also rather suggests what might be called an epidemic. It is our opinion that each such group of cases had some common source of infection, possibly among the patients under treatment in their hospital about that time.

Of the sixty, one entered upon training at the age of seventeen, fourteen at the age of eighteen, twelve at nineteen, eight at twenty, six at twenty-one, six at twenty-two and thirteen between the ages of twenty-three and thirty-one. A few years ago twenty-two was the youngest age at which training for nursing began. It is significant, perhaps, that three-fourths of this series began training before twenty-two, and some had even finished their training at that age. In the earlier series of ninety-nine, the age at entering training was given in only sixty-eight. However, fifty-five of these, or eighty-one per cent, had entered before or at the age of twenty-two.

In the main series of sixty, fifteen broke down before the age of twenty, and thirty-four, or more than half the series, before the age of twenty-two. Between the ages of eighteen and twenty-four, forty-three broke down. The remaining seventeen developed symptoms between the ages of twenty-five and thirty-eight.

There was a positive family history of tuberculosis for fifteen of the sixty, or twenty-five per cent, and in the earlier series of ninety-nine cases a positive family history for fifteen per cent. In some of these there is little doubt that a latent focus existed on entering hospital and became active on account of lowered resistance or massive re-infection. However, the fact that only fifteen in our series of sixty, or fifteen of ninety-nine in the other series, gave a positive family history, making all allowance for errors in the histories and lack of knowledge of family antecedents, would help to support the presumption that in most cases the infection which caused disease was received while in hospital.

Twenty-four of the sixty knew, or thought they knew, of contact with tuberculosis while in training. Some had no idea whether they had or not, and not quite all were questioned as to contact.

The sixty nurses gave a record of a total of two hundred and fifteen illnesses, or an average of three or four each, before entering training. These, as would be expected, were chiefly, and in order of frequency: measles, chicken pox, whooping cough, scarlet fever. otitis media, sinus infection and "colds". Four had erythema nodosum, but this may, perhaps, be considered a part of their present illness and so will be discussed separately.

As will be seen, the nurses of this series entered hospital young. Most had been brought up in fairly good homes, under average or above average conditions, with time before entering hospital only for school. Few had done any definite work or had had much responsibility to carry. It is not surprising, then, that forty-five of the sixty found the work definitely harder and hours longer in the hospital than they had been accustomed to. In hospital, the environment, routine, and even the food were different. The period of probation was one of hard work and some worries. With the actual work of nursing came more responsibility and increased emotional and physical strain. Besides hard work, there were classes to attend and studies to pursue. There had been for almost all an increase in social obligations or opportunities, even if only among the pupil nurses themselves. The hour of rising was necessarily much earlier, and they got to bed, whether necessarily or not, mostly later. In all these changed conditions there was much to lower resistance, even though there may have been elements in the life to increase resistance also.

Their breakdown had no special relationship to any particular hospital service. Some considered that the harder services played a part, and most had the idea that night duty was unfavourable. In the series of ninety-nine cases, seventeen had been on eight-hour duty, fifty-seven on twelve hour duty, and for twenty-five the hours were not stated. Forty-three of the sixty developed symptoms of tuberculosis while in training, though three of these graduated before they came for treatment. Twenty-five broke down during the first half of their course, eighteen during the first year, thirteen in the second year, and twelve in the third year. Four fell ill in the first three months and twelve in the first eight months of their training.

Of the twenty who came to the Sanatorium as graduates, ten had broken down during the first year after graduation. It is very interesting to note that eight of these had remained in their hospitals on staff positions. Three years after graduation five more had broken down, by seven years four more, and for one the breakdown came seventeen years after graduation, though she had had a pleurisy even before training. During training and in the five years following, fifty-five out of the sixty broke down. It appears to be a very striking fact that the period of training and the time of breakdown correspond so very closely. In the three years of training and one year after, fifty of the sixty had their breakdown.

The Clinical Study of the Sixty

Thirty-four had what might be called an acute onset and twenty-six a more insidious onset. A few of those who developed basal lesions had such a very acute onset that their disease was considered not unlike the childhood type.

The relationship of the onset of symptoms to the diagnosis varied. Fourteen were correctly diagnosed within a few days or a week after the onset of symptoms, twelve within a month, and twelve within two months, or thirty-eight in all within two months of developing symptoms. Most of the rest remained undiagnosed for from three to twelve months. For comparison, a study was made of the last sixty women, apart from nurses, admitted to the Sanatorium. Sixteen of these were diagnosed early, sixteen moderately early, and twenty-eight late in their disease. Using the same standards of classification in the series of sixty nurses, thirty-seven were diagnosed early, sixteen moderately early and seven late. The nurses were diagnosed much earlier, and that meant that they also got treatment much earlier. Earlier diagnosis of nurses in training should be expected, since their place of work is in hospitals whose whole business is the caring for disease. The x-ray was easily accessible in all cases. General hospitals are now realising the definite possibility of tuberculosis among their nurses, so are much more alert regarding its early discovery. Another reason for earlier diagnosis is that nurses, as a rule, had an onset of disease with more acute symptoms, and so required medical attention early.

Cough was remembered as the initial symptom, or at least as noticed early, by thirty-six; pain in the chest by thirty-one; tiredness by twenty-six; elevation of temperature by twenty; expectoration by fifteen; and loss of weight by thirteen. Haemoptysis was the first symptom noticed by six. Other symptoms, complained of less frequently, were: frequent "colds," weakness, fainting, nervousness, hoarseness, malaise and dyspnoea. In cases in which peritoneum, kidney, or eye were diseased, the early symptoms were referable to those organs. Four had erythema nodosum and later developed pulmonary disease. The most frequent early symptom-complex was cough, tiredness, pain in the chest and elevation of temperature.

In twenty-five the lesions were mainly apical, and thirteen of these had gone on to cavity formation. Nineteen (one-third of the pulmonary cases) had hilar or basal lesions. One had typical miliary disease and died, and one a miliary spread resembling very much that of the former, but she is alive and well, though still "taking the cure" at home. Nine had generalised bilateral fibro-caseous disease. Twenty-four of the sixty had cavities as shown by x-ray plates on admission. Of these, four are dead, twelve are still on treatment, and eight are working. Nineteen had the right lung involved, twenty-three the left lung, and fourteen both lungs.

Twenty of the sixty had a pleuritic onset, eighteen of these with effusion and twelve with definite parenchymatous disease. Four had tuberculosis of peritoneum, two of kidney, one of eyes, and one of glands.

Erythema Nodosum.—Four of our series, as has already been stated, had erythema nodosum. All these were pupil nurses and had returned to duty as soon as their illness subsided. All later developed pulmonary disease of the acute hilar and basal type.

General hospital people, and we of the Sanatorium, have been impressed by the large number of nurses who have developed erythema nodosum. Opinions still differ as to its etiology and significance, but from our experience, especially in the case of nurses, there is but one safe procedure, and that is to consider it a manifestation of tuberculosis and to treat it as such. A physician of wide experience in tuberculosis, on the staff of a general hospital, and one much called in consultation about suspected nurses, states that when erythema nodosum patients are put to bed for from three to six months and treated as tuberculous people they almost invariably do well, whereas if not given this rest in bed they very often go on to definite pulmonary disease. Erythema nodosum, we consider, should be classed as in about the same relationship to tuberculosis as pleurisy with effusion. All who have had either pleurisy or erythema nodosum should have the significance pointed out and should have periodic, careful examinations, with well-taken and well-read x-ray plates of the chest. Dr. H B. Cushing, in *The Canadian Nurse,* June, 1928, points out that the relationship of erythema nodosum to pulmonary tuberculosis, especially among nurses, is definite.

Is there a special type of tuberculosis in nurses? Of the sixty, eight in x-ray plates and by physical signs showed disease extending out from the hilus, and eleven showed disease mainly in the bases of the lungs; that is, nineteen, or more than one-third, of those with pulmonary disease had either hilar or basal lesions. This type of tuberculosis is not common; indeed, it is frequently stated that primary basal lesions in adults occur in less than one-fourth of one per cent of cases. The proportion among the nurses of this series is therefore relatively extremely high.

Seven of the nineteen nurses who had basal lesions were graduates who had remained on the nursing staff in the hospital; twelve were still in training, nine of these being in their final year. With this same basal type nine were twenty-two years of age or less at the time of breakdown, and the remaining ten were from twenty-three to thirty-one. Six gave a definite family history of tuberculosis, and nine recalled definite opportunity of infection while in training. All but three had found the work in the hospital much harder than they had been accustomed to before entering. Fifteen of the nineteen had an acute onset of symptoms. Nine had their onset with pleural effusion, and when the effusion cleared up revealed underlying acute basal or hilar lesions in the lung. Nine had cavities demonstrable in x-ray plates. Seven in this series with basal lesions were treated by pneumothorax. The four who had erythema nodosum all belonged to this basal lesion series. At the present time, ten are working, eight are still on treatment, either at the Sanatorium or at home, and one is dead.

It would seem to us associated with hospital training and work that there is a special prevalence of this acute type of disease. The majority in this special series with basal lesions broke down toward the latter part of their course or while in hospital work soon afterwards. More than half of them entered training before the age of twenty and broke down before the age of twenty-one. One-third had a positive family history of tuberculosis, and half of them knew of possibility of infection with tuberculosis while in hospital. In nearly all there was an acute onset, pleuritic in nine, with real underlying pulmonary disease. Erythema nodosum, which may be an allergic manifestation of tuberculosis, occurred in four. We offer as explanation of the special type under these special conditions the suggestion that most of these girls had very little tuberculous infection before entering hospital and consequently little opportunity to build up an immunity. They then, while resistance was lowered by unaccustomed work, and while among cases in the wards in which tuberculosis was a background disease, had opportunities to become heavily infected and so developed disease of a type not very unlike that in children who have met with massive infection.

Treatment

Of the sixty, seven were examined and advised at the Sanatorium from time to time, but were not admitted. Seven were in the Sanatorium more than twenty-four months; thirteen from twelve to twenty-four months; thirteen from six to twelve months; nine from three to six months; and eleven for three months or less. Seventeen had artificial pneumothorax. Fifteen were given employment on the Sanatorium staff for a time, and thus were kept under supervision and tried out. Nine of these latter were among those who had pleurisy with effusion which had been cleared up by several months in bed.

Pneumothorax is more urgently indicated in acute hilar or basal disease than in ordinary apical disease. Many had a very acute allergic type of onset and cavitated almost immediately. In these especially pneumothorax should be begun at once. If it is begun early, collapse is usually selective and does not have to be kept up as long as in cases of the usual types with more fibrosis. Most of those of all types who began treatment early did well.

Of the sixty, thirty-one are now working and in apparently good health. Twenty-four are still on treatment, ten of these at the Sanatorium and the remainder at home, and almost all doing well. Five of the sixty are dead.

Conclusions

1. Sixty nurses have been admitted to this Sanatorium during the past five years. This is far beyond the proportion in which women of the Province in general, or any other class of women in the Province, have been admitted, and more than the proportion of girls of their average age also.

2. These nurses, who have come for treatment of tuberculosis, have with very few exceptions broken down

during their training in general hospitals, or during the first year after that training, often while still on the staffs of general hospitals.

3. Fifty of the nurses in this series broke down during their training or within one year of graduation. This constitutes about six per cent, or one in seventeen, of the nurses in training within Manitoba during the same four-year period.

4. We consider that among the unfavourable conditions are the early age of entering upon training as nurses, the previous freedom of these girls from contact with disease, the softness of those unaccustomed to hard work, the comparatively little tuberculous infection they had met and the consequent lack of immunity built up. If nurses were not allowed to enter upon training until twenty-one years of age perhaps fewer would develop tuberculosis. The hours of work are, perhaps, well regulated, but it is important to investigate the *hours of energy expenditure*. Supervision should be strict and the hours of sleep adequate.

5. Nurses on entering training should have a complete physical examination, and well-taken and well-interpreted x-ray plates of the chest.

6. An unfavourable condition in all general hospitals, we consider, is the presence of patients who are under treatment on account of special illnesses and needs, for operations, on account of fractures, childbirth, etc., etc., who have general chronic disease as well, which is not always fully enquired into, and which may be and often is at an infective stage.

A man had an ischio-rectal abscess and during five years had several operations in general hospitals. After the latest of these the wound sloughed and would not heal. On examination of the chest, then, he was found to have gross disease throughout both lungs with cavities, and on questioning him it was found that he had had cough and expectoration for years. No special precautions had been taken about his cough or expectoration. It can easily be seen that nurses not on their guard could easily be infected in the care of such cases.

7. General hospitals could be made more safe for their nurses. *All patients entering general hospitals should have a thorough history taken and a complete physical examination.*

Tuberculous people in general hospitals may be safely treated if known and classed as tuberculous, and if the training and experience of the nurses includes the essential measures for the care of the tuberculous. But undiagnosed and "untagged" tuberculous patients are always a danger, and especially so if the routine teaching and training of nurses in general hospitals do not include measures necessary for the proper and safe care of the tuberculous.

Nurses should receive definite and ample teaching about tuberculosis and the routine for tuberculous patients. *A cough is practically always dangerous, whatever the cause.* Every cough should be covered. Apart from tuberculosis, much could be done to prevent the spread of other upper and lower respiratory infections. Nurses presumably are instructed about the care and proper disposal of all other discharges and excreta, but the dangers of cough and expectoration they do not know so well. A woman recently admitted from a general hospital where she had been for six weeks, under treatment for advanced tuberculosis, had never been instructed to cover her mouth while coughing.

It is very rare to have a Sanatorium nurse break down with tuberculosis. Some reasons for this are: the work on the whole is less strenuous, routine and energy expenditure, apart from nursing duties, is usually of a quieter variety; all patients are known to be tuberculous and considered infective; proper precautions about cough and the disposal of expectoration and discharges are carried out. And it is also considered that by repeated small doses of tuberculous infection some immunity is established. The Lady Superintendent of the Trudeau Sanatorium, in which there is a school of nursing for women who have been tuberculous, but who, in affiliation with general hospitals, take a regular course of nursing training, states: "These students begin with a definitely known handicap, but with the well regulated life they lead they are able, for the most part, to go through with little difficulty."

8. There is a special type of tuberculosis to be made out characteristic in the nurses of this series. Over one-third of them had basal or hilar lesions. It is somewhat similar to the type of disease in childhood, and likely the causes are the same. Children who have been kept away from infection develop acute disease, often basal. Young nurses from good, careful homes have met with little infection and developed little immunity, so if they meet with infective cases, especially if resistance is lowered, and are not on their guard and protected by a proper routine, they are virtually in the position of children.

9. If treated early, and especially with pneumothorax, most of those with basal lesions do well.

Health Insurance

By J. W. McINTOSH, M.D., D.P.H., M.O.H. for Burnaby, B.C.

The time at our disposal is only forty minutes, of which about fifteen minutes is desired for discussion. Considering the scope of the topic, and the amount of the literature, it means only an outline, including the point of view of your profession of graduate nurses. For convenience, I am taking it under nine headings.

I. DEFINITION OF HEALTH INSURANCE.

As fire insurance is a provision for the loss by fire, and life insurance, against death, with other added features, and accident insurance, against the results of accident, so sickness or illness insurance is to secure benefits during illness.

Health insurance provides an opportunity while well and earning wages to insure against a time of illness so as variously to provide, in kind,

medical attention, medicine, etc.,
nursing and hospital provision,

and perhaps, cash benefits.

Health insurance (or sickness insurance) is a method by which the economic loss caused by sickness is distributed amongst a group of persons.

The distribution is effected, by the payment of periodic premiums, on the part of members of the group. In this way the cost of sickness, arising from the stoppage of income, from fees of doctors, nurses and hospitals, cost of medicines and extras, does not come as a sudden financial burden to the individual, but is anticipated by previous payments, and with distribution of cost, over others. (Vide "Principles of Health Insurance," by Dawson.①)

II. HISTORY.

For a long time in parts of Europe, the United States of America, and Canada, there has been some form of "illness or sickness insurance," in fraternal and benevolent, or other organisations. The first extensive state health insurance was introduced into Germany by Bismarck in 1883, over 46 years ago. From there it gradually spread all over Europe. In Great Britain, Lloyd George introduced it in 1911, over 18 years ago, and more recently Northern Ireland and the Irish Free State have followed suit. Now it is in vogue in all Europe, with the exception of a few of the minor states, with a combined population of less than a quarter million.

There is as yet none in the United States or Canada, although the question has been studied by commissions and other parties, e.g., the California Commission. (Vide Labour Publication pages 201-8.①)

In Australia there is a Royal Commission Report recommending its adoption, and it is generally under-

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(Address given on March 14th, 1930, before the Institute for Public Health Nurses, under the auspices of the Provincial Board of Health and the Department of Nursing and Health, University of British Columbia.)

stood that the present Labour Government will introduce a measure for all Australia.

In the Union of South Africa a commission is now studying the question.

In Canada, British Columbia was the first to take the question up. I had the honour of introducing it in the Legislature in 1920. A Royal Commission was appointed which reported favourably. When some years later, another effort was made in Victoria, it was sidetracked to Ottawa.

Ottawa appointed a Select Standing Committee on Industrial and International Relations, which met during 1928 and 1929. Their investigations included health insurance, but their interpretation of the British North America Act put state health insurance under provincial jurisdiction. However, the Premier of Canada has announced that they are prepared to consider collateral action with the provinces, as in the Old Age Pensions measure, giving a basis by enabling legislation, and prepared to assist morally and financially, but not undertaking any health insurance administration.

The British Columbia Legislature on February 1st, 1929, appointed a Royal Commission, which presented a Progress Report② to the Legislature on February 11th last. This practically anticipates a recommendation of action if continued in being as a commission. More recently the commission has been duly authorised to continue its work.

The province of Alberta is also now active on this question.

III. Need for State Health Insurance in Canada and in British Columbia.

Sickness surveys in cities and separate industries in the United States show about 2 per cent. of wage earners on the average off-work all the time through illness, each with an average of seven days per annum. Illness brings the double calamity of no wages. If hard pressed or indigent the wage earners may have no doctor or nurse or secure them too late, and they may start back to work too soon.

In Rochester, New York, a survey of the Metropolitan Life Insurance Company showed that 39 per cent. of the cases of illness did not have a physician in attendance.

State health insurance is needed for all to make it better for the doctor and the nurse to prevent disease, than to cure it.

It is needed by the doctor and nurse to remove the necessity for free attendance on the poor and thriftless.

It is needed by the hospitals whereby a system shall be provided that will put their finances permanently upon a paying basis; and it is needed in maternity work to systematise it, so that the present excessive death rate will be curtailed.

The industries of British Columbia need state health insurance in order that they may compete with the world: this province must equal and surpass other countries in the care and protection of the health and well being of her workers.

To quote Prof. Irving Fisher of Yale: ("Labour Legislation," page 9, et seq.①)

State health insurance is needed in the United States

(1) to tide the workers over the grave emergencies incident to illness,

(2) to reduce illness,

(3) to lengthen life,

(4) to abate poverty,

(5) to improve working power of the workers,

(6) to raise the wage level,

(7) to diminish the causes of industrial discontent,

(8) for the employer, to increase the quantity and quality of output.

"It is not a panacea but," he says, "there is no other measure which equals the power of health insurance toward social regeneration."

IV. Extent { of Area. / of the Populace.

A. *Area*—(a) Individual cities or municipalities. Not feasible as domiciles intermingle.

(b) Canada wide: federal authorities disown it except to assist.

(c) It is therefore up to the individual provinces.

The eastern provinces are not so much alive to the question as the western provinces, so it is fortunate that its adoption is to be left to each province.

British Columbia is acting and ready.

Alberta has taken the matter up.

Saskatchewan and Manitoba are interested.

B. *Populace*—The more universal it is made the better, but there are difficulties and objections to overcome. So it may be considered best to start with employees only.

Some would limit it to those earning below a certain wage, as in many of the European countries.

If started in a restricted sphere, experience can then later decide where and when to expand, as to other individuals and as to limit of income, if any.

V. Plan of Insurance: Voluntary or Compulsory.

The British Columbia Commission states, "In recent years it has become almost everywhere accepted, that, to be effective such insurance must be compulsory." (Page 12.②)

Examples of both plans—In Germany it has been compulsory since the start (1883). In Denmark since 1892, and Belgium and France it has been voluntary. France objected to a compulsory plan largely because it was German. Since regaining Alsace and Lorraine the contrast there with themselves was so great that they have changed to compulsory.

Denmark, though successful with the voluntary plan, as 57 per cent. of the people used it, now sees advantages in making it compulsory.

In Great Britain it is compulsory for the employees who are included, with permission for voluntary members not included in the scheme. In England the administrative cost is only 14 per cent., which is one-quarter to one-third of the cost under voluntary systems.

It will have to be decided whether to allow benefit associations, industrial organisations, transportation companies (e.g., C.P.R. and C.N.R., B.C. Electric and B.C. Telephone Co. in British Columbia, in which insurance is compulsory for all employees), and insurance companies, to continue to operate, bringing them more or less under government supervision, for standard and mode of operation, and then to alter or amend the plan as experience may point, or decide as being for the general or special welfare.

VI. Scope (a) of Interests Affected
(b) of Benefits Secured.

(a) It is recognised that three parties are responsible for illness of the working man (vide Warren, pages 38-43 ③), namely: the employee, the individual himself, governed by his mode of life, etc.; the employer who provides the working environment under which the employee works; and the public who constitute the general hazard of infection and safety of general conditions. So all three parties can be assessed for the cost.

(b) *Scope of Benefits*: 1. Sickness or illness including provision of doctor and nurse.

To which may be added as desired:

2. Periodical examinations now done by (a) Life extension institute—insurance co.'s. (b) Medical examination clubs. (c) National examination campaigns.
3. Hospital and other services.
4. Funeral expenses.
5. Maternity benefits.
6. Cash subsidy.
7. Benefits for unemployment.

(c) The scope may include only the services of the practising physician in attendance, as in Great Britain, or include specialists, to be provided by the insurance system.

VII. Methods of Insurance.

(1) The system may insure the employee only, or the employee and his family.

(2) Employment of doctor—by the panel system, with choice of doctor for a set term, as in Great Britain at first, but not now, or with free choice of doctor. (Vide Warren, pages 59-61,③ also Lambert, pages 36-65,② and Fitzgerald.⑦)

(3) Employment of nurse including one or more of the following plans: (a) full-time group of nurses; (b) free choice of nurse; (c) part-time nurse, with calls at homes.

(4) If maternity benefits are included, whether to use trained nurses or midwives, or both.

(5) Hospitals may be included in the insurance scheme or excluded.

(6) Management of scheme in British Columbia.

A. Health insurance system under the control of the medical profession.④

B. Separate health insurance board.

C. Under the Workmen's Compensation Board—extended.

D. Co-ordination of benefit associations, etc., with the state system as in Great Britain (Vide Warren, page 65②), who claims that the government system is the best. (Vide also ⑤ and ⑥.)

VIII. COSTS.

1. Plans for the apportionment of costs to employee, employer and state. This varies in different countries with percentages.

	Employee	Employer	State
from	50.	50.	*Nil
to	33.	33.	33
and	40.	40.	20

(* As with the B.C. Workmen's Compensation Act, or a varying minimum.)

This last mentioned apportionment seems now to be meeting with favour by authorities writing upon the subject.

2. *Disbursement to the Doctor*: This may be either by the panel system, with the doctor paid per head or per family, per annum, or per call. Doctors want to be paid per call, but the claim is made that costs will tend to go too high with some doctors making too many calls.

If paid per annum per head the great call is to prevent sickness. If paid per call, this incentive is removed.

With free choice of doctor the question arises of how paid for, if per head per annum, under a frequent change of doctor. The question has been raised of collusion between doctor and patient to lengthen out the illness unless there is an incentive to cure up quickly and prevent illness. Some check may be held by a system of referees.

3. *Cash Payments to Insured*: Shall this be in whole or in part?—varying up to 66⅔ per cent. If there is a cash disbursement in lieu of wages, only a percentage should be paid of what would be earned if working, otherwise we all know some who would never be well.

4. Malingering as a factor has not been found to be great.

5. The nurse—she needs to be paid for work done, as she usually would be not quite on a par with the doctor as to piece work.

6. Hospital charges, whether included or excluded in the arrangement, will of course make a difference in the cost of the insurance to the various parties concerned.

IX. RESULTS EXPERIENCED IN EUROPEAN COUNTRIES AND ANTICIPATED HERE.

A. *By Employer*:

1. Less interruption in the continuity of services of experienced employees.

2. Average duration of experienced employees' efficient working capacity is extended.

3. Greater output per man.

4. Better quality of output, therefore better dividends returned to employer.

5. Less cost in outlay for sickness.

6. Greater facilities for caring for what illness there is.

7. In the money paid out in compulsory health insurance the employers find in the final analysis that

there is less for them to pay than there was before, in other ways.

8. The reserve funds if they are diverted to health protection measures thus further reduce sickness and its costs; or they may be applied to reduce the health insurance rates.

B. *By Employee*:

1. Health standards are improved (Great Britain, Sir Geo. Newman.⑨)

2. In Great Britain the employee now receives benefits in kind just over 50 per cent., and in cash just under 50 per cent.

3. Average duration of his working capacity is extended.

4. Reduction in hospital and medical costs with increase in credit balances in sickness insurance.

5. There are reserve funds which are used for health protection, education and propaganda, establishment and operation of hospitals, sanitoria, convalescent homes, laboratory and scientific equipment and special clinics; or, they may be applied to reduce cost of health insurance to all parties concerned.

6. Warren draws attention to the workers' present inability to get adequate medical attention. (Vide③, pages 43-47.) This is relieved.

Sir Arbuthnot Lane said, "Compulsory health insurance systems in Europe already have lengthened the normal life of industrial activity by years."

Dr. Zacker of Germany, the most eminent health insurance authority in the world, states: "That 12 years were added to the average life span of workers during the first 30 years of health insurance in Germany," and Dr. Louis I. Dublin for the Metropolitan Life Insurance Company claims a similar beneficial result. (Vide Victoria Report, page 21.⑧)

C. *The State*:

1. The industrial result is better output from increased efficiency of the worker with less time lost from illness.

2. The financial result is that taxes are more easily paid.

3. The hospitals are less burden on the state for upkeep; these now cost the B.C. Provincial Government over $1,100,000 per annum.

4. A higher standard of physique in its citizens due to a much more extended medical service to the people.

5. The cost of other welfare work would be reduced. (See Warren, page 64, re Relief and Charity Work.③)

6. Dr. Grant Flemming says, "I know of nothing which seems to offer as much for disease prevention as health insurance, in some form. (Evidence before Ottawa Commission.②)

D. *Hospitals*:

1. Finances: (a) Reduction in number of non-pay cases. (In U.S. hospitals now, 50 per cent. pay in full; under 20 per cent. pay in part, and over 30 per cent. pay none. In Vancouver General Hospital 45 per cent. pay none.)

(b) By getting their money, they are put on a paying basis, and no more deficits.

(c) Added equipment and efficiency as a consequence.

(d) Greater specialisation possible.

Dr. Grant Flemming says, "Compulsory health insurance would relieve our hospitals of a big burden." (Evidence before Ottawa Commission.②)

2. General scientific organisation of the whole hospital system may be secured to serve the whole country.

This is much needed in British Columbia at the present time, while the hospital situation in and around Vancouver is under review.

E. *Doctors*:

This is a big department, but as there is no time to dilate upon it, I will only enumerate a few of the advantages experienced in countries that have adopted state health insurance. In Great Britain the doctors fought health insurance hard. Dr. Alfred Cox, Secretary, British Medical Association, has stated, that now very few doctors would care to revert to the old system. (Vide Victoria report, page 19.②) This is confirmed by Sir Geo. Newman, Chief Medical Officer of the Ministry of Health, England. (Vide page 18, same report.② Also by Warren, in his Summary and Conclusions, pages 68-70.③) In Ontario, the doctors seem to be more or less opposed to state health insurance. In British Columbia in 1920 they were opposed, but now they are for it.

Some advantages secured to the doctors:

1. Collections now poor (50 per cent. to 75 per cent.) become 100 per cent in the service.

2. Less volunteer service.

3. On account of present expense to patient, there is curtailing of valuable longer observation. This obstacle is removed.

4. Maximum chance of seeing patient earlier.

5. Maximum chance of examination when well. so as possibly to eliminate potential causes of future illness in those insured.

6. Eliminate contract practice now with the few. thus to minimise this method of taking patients wholesale from other doctors.

7. Head off sundry cults which are now flourishing.

8. May have better hours, thus the doctor is in shape for better work. At present there is often a stampede at 2 a m. on account of the money consideration.

F. *Midwives*:

Our maternal mortality is too high: it is much higher in Canada without state health insurance, than in England with it. A campaign to reduce this rate in Canada is necesary. If state health insurance includes maternity benefits, it must provide for both hospital and home attendance, prenatal as well as natal and postnatal.

The question of the recognition or not of midwives is a question which will require the attention of graduate nurses.

G. *Nurses*:

1. Employment. There are 39 per cent. of people now without medical attendance. In health insurance, when they are included, there will be more calls for nurses.

2. Collections within the service. 100 per cent.

3. Chance for new full-time nursing service, especially in preventive work, in educational work, in the campaign to lower maternity mortality, and in the campaign to lower infant mortality rate.

4. More opportunity for positions of authority and promotion for merit (industry and skill), with chances to rise, in a well organised system of state health insurance with maternity and other benefits.

IMPORTANT: Nurses should organise *re* the whole health insurance question:

1. With a watching brief prior to legislative enactment.

2. With educational and press propaganda.

3. With active representations to the powers that be, bearing upon their recognition and status.

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The British Medical Association Meeting

By ROSS MITCHELL, M.D., Chairman Publicity Committee, British Medical Association Meeting, 1930

Beginning on August 26th, the British Medical Association will hold its 98th Annual Meeting in Winnipeg, the hosts on this occasion being the members of the Canadian Medical Association, with Dr. Harvey Smith of Winnipeg as President-Elect of both Associations. Each has a long and interesting history, the Canadian Association dating from 1867 and the British from 1832. The founder of the latter was Doctor, afterward Sir Charles, Hastings of Worcester, a most gifted and successful practitioner, with marked public spirit.

The first name of the Association was the Provincial Medical and Surgical Association. It was organised in the Board Room of the Worcester Infirmary on July 19th, 1832, the number of members at the time of the meeting being 104. In 1846 the name of the Association was changed to its present form. At the present time it has a magnificent home in Tavistock Square, London, on the site of one of the homes of Charles Dickens, its branches are found all over the globe wherever the Union Jack flies, its members number 35,000, and its patron is His Majesty the King.

The Winnipeg meeting will thus be an Empire festival. In addition to four hundred delegates from the British Isles there will be official delegates from Australia, South Africa, India and Ceylon, as well as two thousand or more members of the Canadian Medical Association. The neighbouring republic will be represented by official delegates and by many others who have made notable contributions to medicine.

The scientific sessions will comprise the meetings of fourteen sections: Medicine; Surgery; Obstetrics and Gynaecology; Bacteriology and Pathology, Physiology and Bio-Chemistry; Diseases of Children; Mental Diseases and Neurology; Opthalmology; Otology and Laryngology; Public Health; History of Medicine and Medical Sociology; Tuberculosis; Radiology; Anaesthesia; and Orthopaedics.

A few of the topics to be discussed are: Poliomyelitis; Thoracic Surgery; Uses of Radium in Gynaecology; Albuminuria of Pregnancy and its late results; Immunological Problems in Septicaemia, Disorders of Sleep; Abnormal Mental and Nervous Symptoms associated with the Menopause; Incipient Cataract; Tuberculosis and Children; Radium in Cancer Therapy; Anaesthesia for Operation upon the Gravid Uterus; and Congenital Dislocation of the Hip. Sir James Barrett of Melbourne, Australia, will give a paper on the Victoria Bush Nursing Association, which has proved wonderfully successful.

In the afternoons and evenings lectures will be given by such men as Sir Farquhar Buzzard, Regius Professor of Physic at Oxford, Sir Lenthal Cheatle of London, Sir William de Courcy Wheeler of Dublin, Professor Dixon of Cambridge, Sir Henry Gauvain, Lord Dawson of Penn, and Lord Moynihan of Leeds.

One of the chief events on the programme of the Canadian Medical Association is the annual oration, Listerian, Osler or Blackader. This year the third Listerian oration will be delivered in the Walker Theatre on the evening of August 29th by Lord Moynihan, who is not only a surgeon of the first rank but also a splendid speaker. The chairman will be the veteran Dr. John Stewart of Halifax, a former house-surgeon of

Lord Lister. This meeting, as well as other meetings, will be open to the public.

Probably the most impressive and colourful assembly at the Winnipeg meeting will be the Annual Religious Service to be held in the open air in front of the Parliament Buildings. The delegates will robe themselves in academic dress of gown, hood and cap, in the Law Courts, and will march in procession to the Cenotaph, where the President will deposit a wreath, and thence to the Parliament Buildings, where a short service will be conducted by the Primate of Canada, the President reading the lesson. A massed choir, assisted by the band of the Princess Patricia Regiment, will lead the singing.

At a special convocation of the University of Manitoba, honorary degrees will be conferred upon several of the distinguished visitors.

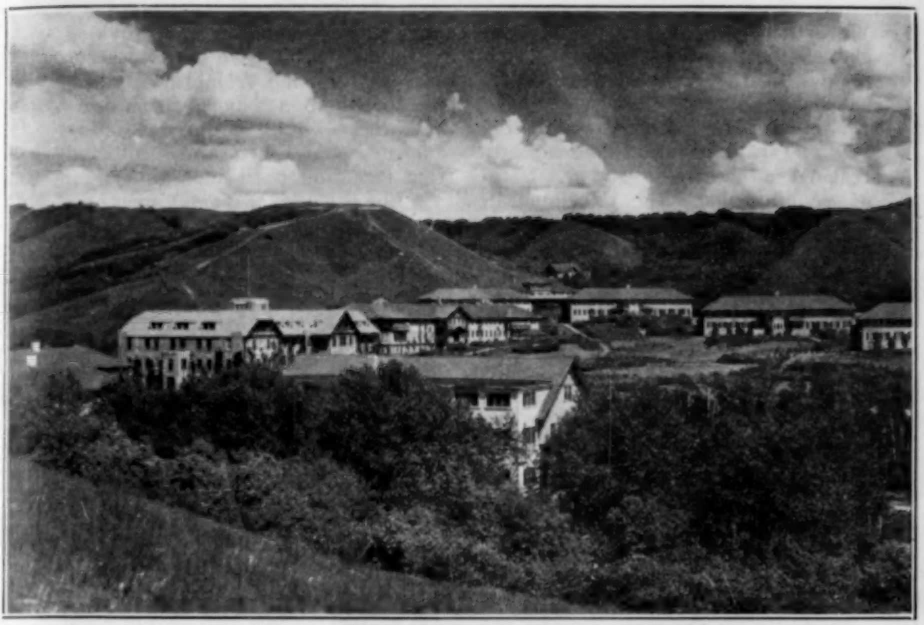
One need only mention the names of a few of the Sectional Presidents: Lord Dawson of Penn, the King's physician; Lord Moynihan of Leeds, Mr. Comyns Berkeley, Sir St. Clair Thompson, Sir Humphrey Rolleston, Professor Muir, Professor Lyle Cummins, Mr. N. Bishop Harman, to give some idea of the distinction of the British delegates. Medical women will be represented by Lady Florence Barrett, Dean of the Royal Free Hospital, London; Dame Louise McIlroy, Mrs. Helen Chodak Gregory, Dr. Gertrude Dearnley, and many others.

One of the principal objects of the Association laid down by its founder was: "Maintenance of the honour and respectability of the profession generally . . . by promoting friendly intercourse and free communication of its members and by establishing among them the harmony and good feeling which ought ever to characterise a liberal profession." The "harmony and good feeling" will be promoted by social gatherings in the afternoons and evenings. More formal social events include the President's reception and dance and the annual dinner, less formal events being garden parties at Assiniboine Park and Lower Fort Garry, an ice hockey and fancy skating carnival at the Amphitheatre Rink, a lacrosse match, alumni gatherings, tennis and golf. The ladies have arranged an interesting programme of social events, both for the visiting ladies and the young people.

The headquarters for the Winnipeg meeting will be the recently opened and well appointed Winter Club on Smith Street. The space used in winter for ice skating will be used as an auditorium seating 2,500 people, while the badminton courts will house the commercial exhibits. The upper lounge will be given over entirely to the use of the ladies and will provide all the conveniences of a social club.

It is a high honour to Winnipeg that the "Gateway to the West" should entertain the British Medical Association. Only on two other occasions, in 1897 when the meeting place was Montreal, and in 1906 when in was Toronto, has the British Medical Association met outside the British Isles. Yet, while this year the place of the meeting is Winnipeg, the British visitors will be made welcome from the moment they land at Quebec. They will be presented with the beautiful "Book of Canada," now being prepared under the joint editorship of Professor Chester Martin, Stewart Wallace, and T. C. Routley of Toronto. Entertainment is being planned for the visitors at every point between Quebec and Victoria wherever their trains stop, and a special tour through the Maritimes is being arranged. Surely nothing but good can spring from this communication between the Mother Land and the Dominion.

May this Winnipeg meeting bind even more closely those ties of friendly intercourse, and establish more firmly the "harmony and good feeling which ought ever to characterise a liberal profession," and thus fulfill the noble ideal of the founder of that mighty Association.



SANATORIUM, FORT QU'APPELLE, SASK.

Saskatchewan's Place in Tuberculosis Work

By R. G. FERGUSON, M.D., Director of Medical Services for the Saskatchewan Anti-Tuberculosis League.

In assessing the place of a province in any health work the consideration of first importance is the interest and intelligent co-operation of the public. In this particular respect Saskatchewan stands high as is evident from the legislation referring to matters of public health in general, and in particular that referring to the eradication of tuberculosis.

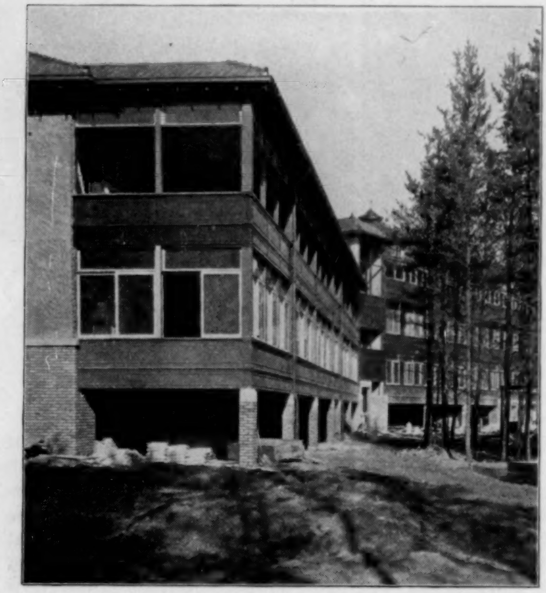
In regard to the actual operation of anti-tuberculosis work, the first essential is the co-operation of the family physicians who have immediately under their care the health of the individuals of the community. In visiting various countries and communities, I have not heard of a place where a better spirit of co-operation in this regard has been evident.

Saskatchewan has splendid sanatoria for treatment. It is true that some of the early buildings which were erected by the Anti-Tuberculosis League and some of those built by the Dominion Government at Fort Qu'Appelle are of a temporary and inflammable nature and now urgently require to be replaced, yet the institutions as a whole are suitable for the purpose, comfortable, and as well equipped as any public tuberculosis institutions in any state or province.

During the past year over 200 people have died in their homes and two-thirds of these had never had the opportunity of sanatorium treatment or sanatorium education. As near as can be estimated, between 150 and 200 additional sanatorium beds would be required to care for the tuberculosis sick in the province.

Were these provided we could then claim a position of pre-eminence in regard to the treatment of tuberculosis.

Facilities for diagnosis are developing rapidly and have already reached a creditable status. Diagnostic clinics have been developed in connection with each of the sanatoria, and in the cities of Regina and Moose Jaw through the co-operation of the medical societies, the hospitals, and the local public health departments. At present, centres where suspects can be thoroughly investigated and observed are within reasonable reach of the greater part of the province. Since these clinics at the sanatoria and in the cities are supplemented by field consultation work among the family physicians in the outlying districts during the summer months, I believe Saskatchewan can feel that it is developing reasonable facilities for the diagnosis of early cases.



SANATORIUM, SASKATOON, SASK.

The first step in prevention was provision for the protection of infants. Accommodation was provided in 1927 for the care of expectant mothers suffering from tuberculosis, and for their new-born infants, so that they could be immediately separated and the infants protected from infection until such time as a safe home could be found for them among friends or relatives. This work was made possible through the assistance of the Imperial Order of Daughters of the Empire, who pay a portion of the cost of the maintenance of this preventorium.

It was not until the funds of the Christmas Seal Sale of 1928 were available that the Saskatchewan Anti-Tuberculosis League was able to enter the broader field of prevention by assisting in providing for the examination of contacts to active cases. During 1929 an effort was made to investigate all contacts to active cases of tuberculosis who are young enough to be particularly susceptible to this disease. Through the co-operation of the family physicians, consultants, clinics and sanatoria, over 2,000 exposed persons have been examined; those who were found to be suffering from this disease have been admitted for treatment.

From the preventive work that is being done results are already noticeable, and we believe that in this way reduction in the number of cases falling sick, and in the death rate from tuberculosis, will be accomplished, and that all those who have contributed to the success of this movement will be well rewarded for their efforts.

Successful Administration Requires Correct Business Methods

By SISTER KENNY, Hotel Dieu, Chatham, New Brunswick.

It was not with any feeling of self-reliance that I acceded to the request of our devoted and energetic President, Reverend Sister Camillus, to write a paper on the importance of practical business methods and good organisation. No, it was rather the desire to show my good-will and to do my little bit to further the praiseworthy activities of the Catholic Hospital Association.

The Hotel Dieu of Chatham is struggling with many administrative problems, which as yet have not been solved; therefore, I may not do more in this paper than open a discussion on this important subject, trusting that many Sisters here, experienced in hospital matters, may have many valuable suggestions to offer us.

The term "business methods" tends perhaps to intimidate the religious as being something foreign to her state; however, a good business working plan with practical methods of carrying it out is in no wise derogatory to high perfection; on the contrary, it helps on our spiritual ideals. Moreover, our desire to have Catholic hospitals with a first class standing or even superior recognition among the best institutions in our land would be sterile without striving after good business methods.

Progress connotes satisfactory service, and to effect this a hospital must have at its head a broad-minded, progressive superintendent, trained in the care of sick, well read in the history of hospital development, and alive to its social problems.

Co-operation Essentials

The superintendent must have the loyal support and perfect co-operation of the officials of all departments; the director of nurses, floor and surgical supervisors, dietitians and pharmacists, x-ray and laboratory technicians, and the entire office staff, inasmuch as progress spells co-ordination and harmony among all these units. A very effective method of securing such is the weekly conferences of the nursing staff, at which general information is given, correspondence read, mistakes in administration set right, etc. The informal and kind manner in which these meetings are conducted preserves and strengthens the spirit of sisterly union among the different members of the staff.

An up-to-date, smooth-running accounting system is an important factor in hospital management and the keynote to its success is again co-operation. The Sisters engaged in the various offices must do their share of the work intrusted to them with reference to the business centre.

The daily routine of office work, making accounts, keeping ledgers, etc., is not in itself a difficult one, yet it is often a problem to the Sister bookkeeper how to secure accurate results owing to some oversight on the part of those in charge of the departments in not sending to the central office a statement of their respective business transactions. To obviate this, a very good working plan is to have each department send in daily accounts. This is a preventive to the danger of omitting any item in the patients' accounts. These slips are placed on a file outside the office door and are collected each evening by the Sister bookkeeper.

Collection of Accounts

With regard to facilitating the prompt payment of accounts or collecting bills, what I am now about to say does not refer to the really needy

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(Read at the annual meeting of the Maritimes Catholic Hospital Association, 1929.)

patients, who are treated free of charge and whose feelings should be considered with the utmost delicacy. But I allude to those who are able to pay, although it not infrequently happens that they are unwilling to do so. To the casual observer it would seem hardly the opportune moment on admitting such patients to welcome them with a demand for a deposit, and yet I think I might remark, however, that as in all things else, our proceedings should be characterised by the greatest courtesy. There is a tactful way and a tactless way of admitting patients, and our aim should be to acquire the former. Place ourselves in the patients' position and do unto others as we would wish to have done to ourselves. My personal opinion about the collecting of bills is that justice should always be tempered with forbearance and charity. I realise that one may meet with more or less imposition, for duplicity is so widespread nowadays that we are apt to be deceived by the would-be honest man; still we must remember that we are religious and should rather err on the side of kindness than on that of rigour.

No doubt the experience is general of the patient who leaving during the middle of the week promises faithfully to send a remittance on Monday, or of the working man who assures the hospital authorities that he will send his government cheque at the end of the month, or of another type more eager still to repay for services rendered bids you *au revoir* with thanks, telling you that just as soon as he reaches home he will send the amount. Alas, Monday never comes, the government cheque has met its fate, and the too grateful individual never reaches home! Thus there are added more items to the already heavy balance sheet of unpaid accounts.

May there not be an error in waiting until the patient is leaving the hospital to have him pay his debt? We think so, and have tried the following remedy. After extending a cordial welcome to the patient, we introduce the subject of business and if at all possible we secure a deposit. Then a statement is sent to the patient every Friday morning and payment is expected that evening or on Saturday. The bill, though it may bear a little bad news, nevertheless is resignedly accepted if on admission this regulation is explained to him. A follow-up system is continued after the patient leaves the hospital by the gentle reminder of a monthly account rendered. Perhaps many hospitals have similar difficulties. Would not the subject be appropriate for discussion?

Each month a bird's eye view of the financial standing of the hospital is imperative, and we have adopted an easy method through a systematised keeping of a synoptic cash journal, so that at a glance we may estimate the revenue, loss, and profit of our hospital during the said period.

I must not overlook the telephone booth. What can be more important than the receiving and out-going calls in a hospital? An intelligent and efficient telephone operator should be conversant with medical terms and should be tactful, alert, interested, obliging, and polite. Information about patients should be given promptly and be at all times prudently accurate, so that the friends and family of patients may feel that the hospital is anxious to serve them as well as their sick in a kindly way.

Now for the last word. While stressing the need and advantages of correct business methods we must remember our hospitals' greatest asset is, after all, the poor. The exercise of charity to the suffering poor is the prime reason for the existence of Catholic hospitals and the foundation of our vocation. Our genuine charity to this class of patients will bring a return of God's blessings upon our work out of all proportion to earth's recompense by the satisfaction which comes with the simple, "God bless you, Sister," from the lips of Christ's poor.

Obstetrical Practice Yesterday and Today

By C. B. OLIVER, M.D., Chatham, Ont.

If I were able to scan the future as clearly as I can recall the past the title of this paper would read: Obstetrical Practice Yesterday, Today and Tomorrow, and it might prove an interesting and illuminating study.

It is forty years since I conducted my first maternity case. I see much of present day obstetrical practice and know much of its myriad shortcomings. For four decades I have been profoundly interested in this work; have always considered obstetrical practice of premier importance and I would like to see, before I close my record, its conduct placed on a much higher level than it occupies today.

A glance at maternity and infant mortality statistics should convince even the casual observer that there is something wrong with present day methods.

Why are the lives of so many mothers sacrificed during labour? Is a large part of this mortality preventable?

Day by day babies are being brought into the world dead, or survive only a few hours. Is there needless sacrifice, and if so, where rests the responsibility?

It is my hope that this paper, written from a somewhat full experience, may serve to correct a few of the errors into which medical men, and more especially the beginners, are prone to fall. If my views help to create a keener interest in this important work and thus bring a little nearer the ideal for which all are striving, I feel I shall have accomplished something worth while.

"The obstetric ideal demands that the mother should pass through labour without injury to herself, and that the babe should be born healthy and capable of normal growth and development physically and mentally."

The failure to approximate, even remotely, that ideal, is the tragedy of obstetrical practice today.

In my library there is a work published in the year 1782 by Dr. John Buchan, of London, England, from which I quote these words:

"Although the management of women in childbed has been practiced since the earliest accounts of time it is still, in most countries, on a very bad footing." One hundred and thirty years later Professor Joseph DeLee, of Chicago, made this startling statement: "It is generally conceded that the practice of obstetrics is on a low plane." Only five years ago Prentise Wilson, of Washington, wrote: "The rate for deaths of infants, attributable to birth injury, has been steadily climbing upward over a considerable period of years." My own experience has convinced me beyond any doubt that the tide is still rising.

What Buchan said of the practice of obstetrics in the closing years of the eighteenth century would hold equally true in regard to medicine and surgery. DeLee's statement, however, over a hundred years later could not be applied to the practice of medicine and surgery, for it is everywhere conceded that it is on a very high plane.

The question for every man practising obstetrics today, is: are these statements true? And if true, to what degree am I responsible?

It may be said without fear of contradiction that the medical profession, speaking generally, entertains very unsound and dangerous views as to the importance of this branch of surgical practice. The average practitioner regards pregnancy and childbirth as strictly physiological conditions. He knows a majority of women pass these periods in safety and always anticipating that each new patient will prove to be one of this majority, he is blind to the

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(Paper given at a meeting of District I, Registered Nurses Association of Ontario.)

dangers the minority have to face and is often ill prepared for the emergency confronting him.

The practice of obstetrics would rapidly attain to a higher level if medical men would take to heart Mauricean's dictum that "Pregnancy is a disease of nine months' duration." If our sole concern is with the actual births we have altogether misinterpreted the meaning of the word obstetrics.

What is obstetrics? Hirst's definition is all embracing: "It is the study of the physiology and pathology of conception, gestation, parturition and the puerperium with all the complications and pathologic consequences of the child bearing act at all periods."

A child has a fall and shortly develops headache and becomes restless and feverish. The mother naturally attributes these symptoms to the accident but very soon examination by the physician discloses the fact that the patient is suffering from tubercular meningitis. The fall proved to only an incident.

So likewise childbirth is but an incident in the great reproductive cycle. We concentrate on it alone and fail to discover the menace that is threatening two lives.

Three to five per cent. of children die during labour and many are permanently crippled. Fifty per cent. of women who have borne children carry the marks of injury and many date a life of permanent invalidism from the birth of their first baby.

How much of the traumatism of labour are we responsible for and how much of it could be avoided if we had a truer conception of the importance of obstetrics? If one were to make the remark in an average company of medical men that he had a special liking for obstetrical practice, the statement would evoke a variety of responses. Some would commiserate, some condemn, a few only would commend.

The attitude of the medical man is precisely the attitude one would expect the laity to assume and one finds it altogether too common in our best hospitals.

To many medical men obstetrical practice is sordid, drab, uninteresting and unremunerative. Their views unconsciously permeate and infect hospitals. The more scars and patches a pair of gloves discloses, the more certain is that pair to find its way to the obstetrical ward. They are not fit for the surgery but anything is good enough for the labour room.

My own view is that no other work a physician engages in can equal in importance and genuine satisfaction the task of bringing healthy children safely into the world.

It is a regrettable fact that so many men practising obstetrics today are indifferent to the claims of the lying-in room and a good many known to me have a positive dislike for the work. And still they carry on, the rush of twentieth century competition the compelling factor.

I am thoroughly convinced that the Theory of Obstetrics is skilfully taught in Ontario but all will agree that facilities for teaching the practical, and most important side of it, are as hopelessly inadequate now as they were in my student days.

With imperfect practical training, new men year by year face difficult obstetrical problems, with a supreme confidence in beneficent nature, which fortunately in so many cases proves equal to the occasion. They promptly refer an eye case to the specialist in that field, but have no hesitancy in assuming charge of a mother in a great crisis where two lives are involved, with little knowledge of the attendant dangers, and utterly lacking the practical skill which alone will meet the emergency.

Men have told me frequently that they had a positive abhorrence of obstetrics. I naturally wonder why they carry on.

Would scores of great surgeons one could name, have reached the eminence they occupy today with such signal benefit to the human race, if surgery had not appealed to them? Would the discoverer of insulin have been able to bless the world with his inestimable gift if he had developed a distaste for research work?

The answer is obvious. The physician who dislikes obstetrical work and still practises it, is not playing fair with posterity.

Until recently, obstetrical fees offered little encouragement to the physician willing to specialise. Even today with largely increased fees the obstetrician is still, proportionately, very inadequately paid.

How many times I can recall taking charge of a toxic case and after infinite watchfulness and unremitting care bringing mother and babe safely through. I remember, too, my fee for that period of stress amounted to anywhere from a third to a half of what my surgeon neighbour received for an appendectomy.

At the same time I feel constrained to sound a warning. The burden of raising a family in some of our larger centres of population is a colossal one, and many young couples will inevitably try to shirk the responsibility.

With hospital, nurse's and doctor's fees totalling one-third of the family income how many times is this family going to repeat? Few people nowadays can afford to die. Is the time approaching when prohibitive obstetrical fees will affect the birth rate? If ideal fees stood always for ideal obstetrics there would be little ground for complaint. But do they? Just why is "A" living in a large city, able to demand six times the obstetrical fee "B" in a small town gets, when "B" has six times the practical experience of "A" and is much the safer man in any crisis?

In what respects is obstetrical practice today superior to that of forty years ago?

I have in my office records the history of nearly 5,000 maternity cases. A retrospect of the decades that have passed since I began practice, together with a study of these histories has convinced me that at least, in some respects, the profession is making progress.

Our aseptic technique, while by no means perfect, is steadily gaining a higher degree of efficiency. For instance, in instrumental delivery and in the conduct of podalic version we do not, and should not, leave the preparation of the field entirely to the nurse, but as a preliminary to the operation the vagina is thoroughly and systematically cleansed with liquid soap and sterile water from the cervix to the vulva by the doctor himself. In addition to sterilising the parturient canal, we obtain, through personal attention to this matter, the gentle and gradual dilatation so essential to a safe completion of the operation.

There is also a growing belief in fewer vaginal examinations. Experience has demonstrated that nearly all information as to position and progress can be ascertained through abdominal palpation alone.

I confess to a change of heart in regard to vaginal douching following childbirth. I once thought that such practice was attended with too much risk to be undertaken only in extreme cases.

Is there any good surgical reason for permitting fetid vaginal discharges to pour over lacerated or abraded surfaces? In such cases repeated douches of lysol, boracic or even plain sterile water will not only cleanse the field but will hasten the process of involution, and what is of almost equal importance will add materially to the patient's comfort.

Then too, the question of allowing maternity cases to sit up has long been a debatable theme. My own practice is to permit every normal case the back rest on the second day, and to sit in a chair for a few minutes as early as the eighth. I have no doubt many would make a speedier convalescence were they allowed out of bed even earlier. This practice assists normal drainage immensely. Inadequate drainage predisposes to

subinvolution, and subinvolution fosters serious malpositions of the uterus. Keeping normal maternity cases in bed for 14 days is a practice with few exponents today.

The rise of the trained nurse who was practically unknown in my early days, has had a most beneficial influence in making for better maternity practice. Her presence at the bed side is a stimulus to more careful, and consequently more successful work.

(To be concluded in July)

Canadian Social Hygiene Council

By **ETHEL GREENWOOD**, Toronto.

At the eleventh annual meeting of the Canadian Social Hygiene Council which was held at the Royal York Hotel, Toronto, concurrently with the Second Canadian Conference on Social Work, from April 30th to May 2nd, 1930, thirty national organisations were represented.

At a very successful luncheon held on the opening day, Mr. Henry E. Spencer, M.P., spoke on "The Health Problem in Canada." The speaker felt that as health was related to such subjects as education, unemployment, insanity, criminality, immigration, poverty, etc., it was much too comprehensive a topic for a luncheon address. Speaking in favour of full-time Health Units as one way of attacking the problem, Mr. Spencer used as an illustration, figures from a district served by a Health Unit in Quebec, where deaths from general sickness had been reduced from 643 in 1926 to 487 in 1929—a saving of 156 lives. Infant mortality had dropped from 213 to 160. Deaths from contagious diseases from 86 to 27. "If," continued Mr. Spencer, "I could influence the administration of various governments in this country, it would be not merely to establish Health Units, but to make available to every human being in Canada free medical examination once a year."

At a later session the Council went on record expressing itself in favour of the establishment of County Health Units as these have a direct bearing on the reduction of disease.

On Thursday, May 1st, Miss Ethel Greenwood represented the Canadian Nurses Association at the luncheon which was followed by a session on Periodic Health Examination. From this section, where some excellent papers were read, came a resolution in favour of an educational campaign in regard to periodic health examination for all age groups.

During its meetings the Council also went on record as approving of the universal pasteurisation of milk.

On Friday, May 2nd, an interesting morning session was held dealing with Venereal Diseases, and after discussion of the papers presented, the Council resolved that it approved of a future routine Wasserman for all hospital patients, and of the establishment of model V.D. Clinics in the provinces.

Miss Edna Fraser, Toronto, represented the Canadian Nurses Association at the closing luncheon, which was followed by the annual Business Meeting with the report of the General Secretary and election of officers. Reports of fifteen standing committees were presented, among which were: Venereal Disease, Communicable Disease, Medical Examination before Marriage, Report on Narcotics, General Paralysis of the Insane.

The Honourable Mr. Justice Riddell was re-elected President, with Mr. Alphonse Lessard, Chief Officer of Health of the Province of Quebec, as Vice-President.

Miss Jean I. Gunn, Superintendent of Nurses, Toronto General Hospital, and Dr. Harris McPhedran, Toronto, were among newly elected members of the Board.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

The Crowe Scholarships

By E. KATHLEEN RUSSELL, R.N., B.A., B.Paed., Director, Department of Public Health Nursing, University of Toronto

We sometimes wonder if the year 1929 did not hold too much for Canadian nurses. At least the International Conference over-shadowed every other professional interest to such an extent that a certain happening of the year, of extraordinary significance to Canadian nurses, was passed by so quietly that possibly little is yet known of it. I am referring to the scholarships willed to Canadian nurses by the late Mr. H. J. Crowe.

In speaking of this gift, I have a keen desire to describe it adequately and, consequently, find myself hesitating about the terms which should be used in the description. With all the emphasis of restraint let us say that Canadian nurses have had a truly magnificent gift in this bequest. Briefly, the provision is that each Canadian province shall have an annual scholarship for a nurse to use for post-graduate study; and that these scholarships shall continue for a period of approximately ten years, perhaps longer; and that Nova Scotia is to have an additional scholarship each year. Furthermore, the Dominion of Newfoundland is also to have one scholarship each year.

The late Mr. Crowe had been living in Toronto for some years and had had some intimate knowledge of the efforts that were being made there to prepare nurses to meet the growing demands of modern medical opportunity. He had also lived in Newfoundland, having extensive lumber interests there, and knew the great difficulties of adequate provision of nursing service for the isolated settlements of that country. And best of all Mr. Crowe knew his native province of Nova Scotia. It was a fine piece of good fortune for our profession that this first great benefactor should have been a man of these wide interests so that the benefaction when it came was conceived in national terms. The value of this arrangement is many-sided or rather many values lie potentially in the gift and are ours to develop if we will.

Primarily there is the fact that every Canadian province is included. Here is a bond to draw together the nine provinces as surely there must, before long, be conference between the various schools that are affected. This common interest is a thing to be grasped gladly in this time when there is so much of divided interest. We understand that these scholarships will be available annually for at least ten years to come. Wisely used, this opens up a wide avenue of opportunity. And inevitably the opportunity carries with it an equal weight of responsibility and it is not an easy task that lies ahead to see that this talent is made to earn an hundredfold of increase. All who have had anything to do with the administration of scholarships know that the whole matter is difficult and dangerous. I suppose the most interesting illustration of this in the history of education lies in the administration of the Rhodes scholarships. Years of thought and study and service have been put into this work by the best brains of the Empire and yet lately we find the trustees embarked upon a fresh survey of their procedure, with serious hope for ever better results. It is to be hoped that the responsibility laid upon our schools by the Crowe scholarships will be accepted with corresponding seriousness.

A practical suggestion can be made at once. In one province the scholar for 1930-31 has already been selected, her course of studies has been decided upon and the intervening months given to preparation (and rest!), advice having been sought upon the use of this time from the graduate school in which this student is to enroll. All this is as it should be in every case if the fullest possible return is to be obtained from the scholarship. A hurried selection of scholars—with equally hurried preparation on their part—was inevitable in September, 1929, but it should be made utterly impossible for that sort of thing to happen again in the awarding of these scholarships. If thought is taken now, it is possible that even emergency situations can be foreseen and provision made against these. Also—and this is a very serious thought—we owe it to the young members of our profession to see that no one dares to accept a scholarship lightly.

A further matter suggests itself. Here is a fine instrument in the hands of certain hospital schools which might be used to advantage in their efforts to raise their educational standards or, even more important, the personal qualifications of the pupils that they are enrolling. Are there schools that are most anxious to improve the quality of their nurses and yet that have been held back by such things as political interference, unintelligent economies and so on? If there be such a school, and methinks I have heard tales of such, could not that school now seek the strength of some adviser from the general field of education and, thus aided and abetted, make this the psychological moment for taking a forward step?

Naturally all of the provinces are looking, not perhaps with envy, but certainly with awe at Nova Scotia, the Benjamin that has received the double portion. This special gift is as it should be and surely the others will rejoice with Nova Scotia in her good fortune, but the small Mayflower Province must pick up her double share of responsibility in return. Two scholarships a year for some ten years or more to come! With this in view there can be little feeling of neglect or professional poverty; and certainly this prize should be an added inducement in attracting good recruits to the home school.

Much more might be written upon this subject and indeed we hope that much more will appear and that speedily. The subject merits much space in our journals and much time in our conferences. Perhaps the first thought is a desire to give adequate thanks for this benefaction. Do we realise that the one way in which that can be done is through making the best possible use of the money. There is only one reason for troubling about the education of nurses and that reason is that the people may have better nursing service. Let us see to it that the Crowe scholarships serve this purpose.

The writer is speaking now from the standpoint of a post-graduate school after ten years of experience with scholarship students. It is this experience that makes us view this new gift with some misgivings. Undoubtedly scholarship moneys are not always used with full wisdom and yet, before uttering criticism, we must view the whole matter in proper perspective in order to understand aright. The first of our post-graduate schools for nurses were established just ten years ago in Canada and our profession as a whole and also our friends rallied very loyally to the support of the new schools, raising scholarships with the particular purpose of making sure that they would have students enough to make a satisfactory start. A great deal of time has thus been saved in the first experimental stage of these schools and we can never be grateful enough for this immediate and practical interest.

Now, however, it appears that a second phase of our work has been entered upon and that a developing use of scholarship funds should follow. Should we not now expect that every beneficiary should have the personal qualities that make for leadership? With all the contingencies of life to intervene, there is not much danger, for some time to come, of our having a too plentiful supply of such leaders. Our ranks appear to be full enough but the dearth of trained officers is rather alarming.

Ideals in Administration

By E. FRANCES UPTON, Executive Secretary and Registrar, A.R.N.P.Q., Montreal

Our nursing journals the world over have contained from time to time valuable writings from eminent leaders in our profession, articles concerning the various problems which confront groups, associations and individuals, and much indeed can be learned from such exchange and interchange of ideas and experiences.

We read of the problems in administration and know that their name is legion: solutions have been found for many, but each day new trials face us.

It has been said, "The science of efficiency is nothing but the most common sense way of doing a thing, and common sense is a matter of the mind, and the mind is man; that real efficiency is attained by the mind controlling and directing effort into proper channels. Obviously the mind of an administrator should be continually developing, but should be at all times a clear, well-ordered mind, open, wholesome, inviting and receptive, a mind reflecting and radiating."

True, the administrator's mind should be all that this writer has suggested, and may I here and now hold out a challenge to all administrators in nursing affairs in this Canada of ours to take stock of themselves, examine their mental and physical equipment, see if all this is in fit condition to carry on the heavy responsibilities of the task in hand, and if such equipment is functioning to its fullest capacity.

Is the human element within us frozen stiff, or do we bestow upon our daily task the benefits of the high explosives of a mighty personality?

Do we understand the problems about us, the financial needs of the institution which we serve, the health problems of the community in which we live, the prevalence of tuberculosis in the country and the "danger signs" of what might be the breaking down of a staff member or student with this disease?

Do we know how many of the young students entrusted to our care taste their first cock-tail after entering a large city hospital, and do we know what to do about it?

Do we know and appreciate the value of discipline wisely administered or do we break the hearts of earnest and conscientious staff members and students because they displease occasionally, and permit misdemeanor in others because they happen to display a little more diplomacy and flatter us not a little?

Do we sufficiently concern ourselves with the execution of our duty or are we spending our best days fighting for our rights?

The teaching of the sciences and the modern nursing methods is, to my mind, the easiest part of the work of our nursing schools today. How to develop the soul of the individual nurse through the inspiration of good leadership, and thereby keeping aloft the ideals of our profession, should be the work of administrators, who must foster in the minds of young nurses the spirit of service and the ideals for which our splendid pioneers toiled.

Deathless loyalty to a moral commitment is our responsibility. There can be no glory without crosses; we cannot achieve success without paying the price and carrying the scars of battle. Are we qualified and ready to carry this load?

(Contributed by the Alumnae, School for Graduate Nurses, McGill University.)

SUMMER COURSE—UNIVERSITY OF SASKATCHEWAN

The Department of Public Health, Saskatchewan, in co-operation with the University of Saskatchewan, announces a Summer Course in Public Health Nursing to be held at the University of Saskatchewan, Saskatoon, from July 3rd to July 30th, 1930. Miss Isabel Manson, B.A., Reg. N., of McGill University, Montreal, has been secured as instructor in Principles of Public Health Nursing. The course, which comprises sixty lecture periods will also include Teaching Principles, Child Hygiene, Mental Hygiene, Nutrition and Health, Tuberculosis, Public Health Legislation and Motor Mechanics.

Arrangements have been made for living accommodation at one of the university residences at a nominal rate.

The course is open to all nurses. Details of the programme may be secured from the Department of Public Health, Regina. Application for admission should be made at once to Miss R. M. Simpson, Director of Nursing Service, Department of Public Health, Regina, Saskatchewan.

A SUCCESSFUL REFRESHER COURSE—UNIVERSITY OF TORONTO

The week following Easter witnessed a successful Refresher Course for Public Health Nurses offered by the University of Toronto. The total enrolment numbered sixty-eight, and included a wide distribution of workers from Ontario, and a few from the Maritime Provinces. To the Victorian Order of Nurses is due the honour of enrolling the largest group—some thirty in all. The Ontario Division of the Canadian Red Cross Society, the Metropolitan Life Insurance Company, Local Boards of Health and Education were also represented.

The content of the course focussed attention upon certain phases of Child Hygiene Nursing. Lectures on pre-natal care, infant and pre-school hygiene, parent-child behaviour problems, and neurological factors in health work were given by members of the medical staff of the University. Closely related to these were round-table conferences which dealt with problems and procedures in current public health nursing practice. The demonstration of a pre-natal nursing visit, and of a communicable disease nursing visit served to make lucid accepted home technique. Through the courtesy of local health organisations observation visits were arranged for students desiring such experience.

Much of the success of the undertaking may be attributed to the Public Health Section of the Registered Nurses' Association of Ontario. For some months prior to the course that group stimulated enrolment, and helped materially in determining desirable content. A tea given by the Section at the close of the week gave tangible evidence of the happy relationship existing between the professional organisation and the University.

The purpose of the Refresher Course is not only self-evident but wholly justifiable in that the student is brought into contact with the most recent theory and practice in the preventive field and, through conference with others of like interests, is able to appraise adopted procedures. One cannot mingle with such a group without catching something of the spirit inherent in the pioneer; that spirit which persists in failure or in accomplishment. Nor can one be apprehensive of a future which rests in the hands of those who are seeking to meet the public health nursing needs of the Province in such a way as to ensure the reflection of native genius, and the perpetuation of worthy traditions.

ANNUAL STAFF CONFERENCE—MANITOBA

The Thirteenth Annual Staff Conference of the Manitoba Public Health Nursing Service was held during Easter week at the Legislative Buildings in Winnipeg.

The programme for the Conference took the form of a series of demonstrations, with round table conferences and instructive talks by officers of the Departments of Health and Public Welfare, Education, and the Extension Service of the Department of Education.

The demonstrations were conducted by members of the nursing staff, to present in a graphic way each phase of the nursing and educational work carried on by the nurses, and were followed by discussion as to methods and problems.

Everyone of the staff entered into the spirit of dramatisation, much to the delight of the audience. Incidentally these demonstrations gave convincing proof of the value of dramatisation as a means of education. Certainly as an enjoyable as well as instructive form of staff education, the use of the demonstration method is to be recommended.

During the same week, the Annual Health Exhibit of school health training work was shown at the Provincial Convention of the Manitoba Educational Association.

The very fine examples of work shown were an indication of the remarkable progress that has been made in school health training and instruction in the Province. The exhibit was assembled through the Public Health Nursing and Health Education Services of the Department of Health and Public Welfare.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss THERESA O'ROURKE, 753 Wolseley Ave., Winnipeg, Man.

Some Present-Day Views on Diet

By E. M. WATSON, M.D., F.R.C.P. (Can.), Assistant Professor of Clinical Medicine, University of Western Ontario Medical School, London, Canada.

INTRODUCTION

There was a time when the question of diet was a matter for serious consideration only during illness. Today, the subject of diet is of general concern and is of importance to the well no less than to the ill. Public health education, radio broadcasts and popular articles in newspapers and magazines have served to enlighten and interest the public in matters regarding food and its relation to health. However, much of the propaganda offered to the public is tinged with commercialism or stresses the not unprejudiced views of the over-enthusiastic propagator. In fact, diet always has had a fascination for the faddist element of the population. We, who are intimately concerned with problems of health and disease, should strive to keep at least a step or two in advance of the general public as regards ability to sift facts from foolishness in the march of modern achievements. Most of us have neither the time nor the opportunity for keeping abreast with the details of scientific progress, unless some particular subject happens to be of special interest to us. Therefore, in bringing to your attention a few of the recent advances in the science of nutrition and diet I shall make no attempt to cover the whole field of dietetics, but will treat briefly with certain phases of the topic which may be of interest to you.

The Functions and Composition of Food

Food supplies the body with latent energy which by the processes of metabolism is converted into actual energy in the form of work and heat. It provides for the re-building of tissues which are continually undergoing destruction as a result of wear and tear. It helps to maintain the normal physical and chemical composition of the blood and tissue fluids, which is necessary for the proper functioning of all the organs. It makes possible growth and development in the young. Each of the primary food constituents has a part to play in this programme.

The energy value of food is expressed in terms of calories or energy (heat) units. The chief energy or fuel foods are the carbohydrates and fats. Protein, besides being a source of energy, forms the building part of the dietary. Water and minerals, while not foods in the ordinary sense of the word, form a very important part of the diet. Water is necessary for the maintenance of the normal concentration of the constituents which make up the blood-stream. Minerals such as salts of lime, phosphorus, iron, iodine, sodium, etc., contribute elements of vital importance to the body. For purely physical reasons, the diet must contain bulk or roughage. This is provided best by the cellulose or fibre vegetables and fruits. An adequate supply of energy, building material, water and minerals alone is not sufficient for proper growth and development in the young or for the maintenance of health and nutrition in the adult. Something more is necessary. The diet must contain certain important but as yet

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(Read before the Edith Cavell Association, London, Ontario, March 31st, 1930.)

little-understood substances called accessory food factors or vitamins.

Vitamins

Vitamins are popular at present, so it might be well to say something about them first. Vitamins have been described as invisible life-savers. While, perhaps, they may not be exactly life-savers, they are at least health-savers because certain definite abnormalities follow their absence from the diet.

Most of our knowledge concerning vitamins has been acquired by noting the results of feeding special diets to animals. But the original observations were of a rather more practical character. In the early days of sailing vessels, sailors on long voyages frequently developed a malady called scurvy. As early as 1804, it became known that when some fresh food, such as lemons, oranges or vegetables, was included in the diet this condition did not develop. Prior to 1885, in the Japanese navy a form of polyneuritis called beri-beri caused considerable disability. This was abolished when barley was substituted for a portion of the polished rice which hitherto had formed the chief ration. It was later learned that the symptoms were due to the absence from the diet of the outer husk of the rice, which had been removed by the process of polishing. It was not until many years later that the real explanation of the above phenomena became known. The term "vitamin" was introduced in 1912.

The various vitamins are designated according to the first few letters of the alphabet.

Vitamin A is known as the "growth-promoting" and "anti-infective" vitamin. Young animals given a diet deficient in this factor fail to show proper growth and development. There is also a marked susceptibility to infections. There appears to be a possible association between vitamin A shortage and the formation of calculi or stones in the urinary tract. This vitamin occurs in abundance in milk, butter, egg yolk and cod liver oil. It is found in green vegetables such as spinach, lettuce, cabbage and cauliflower. Tomatoes contain a rich supply of the factor.

Vitamin B is usually called the "anti-neuritic" vitamin because its inclusion in the diet prevents the occurrence of a form of neuritis which is a manifestation of the above-mentioned disease, beri-beri. Recent investigations have shown that what was originally regarded as Vitamin B really consists of two independent factors, both apparently equally essential to well-being. British investigators have named the two products B_1 and B_2, in America the tendency is to assign the letters F and G to the same individual agents. Vitamin B_1 or F represents the original "anti-neuritic" influence; B_2 or G is referred to as the "anti-pellagric" vitamin, indicating its relation to the disease pellagra. Vitamin B_1 and B_2 occur abundantly in egg yolk, milk, green vegetables and yeast.

Vitamin C is the "anti-scorbutic" factor. Lack of it produces scurvy and allied conditions. This vitamin is present in the juice of oranges, lemons and tomatoes.

Vitamin D is the well-known "anti-rachitic" factor, absence of which from the diet causes rickets. Recent research has also shown that an adequate supply of Vitamin D is necessary for the development of perfect teeth. Vitamin D, like Vitamin A, is closely associated with fats and oils, but not with oils of vegetable origin. The source of supply of both vitamins is much the same. However, cod liver oil contains a richer supply of Vitamin D than of Vitamin A. More is known about the chemical nature of Vitamin D than about any of the other accessory food factors. Apparently the anti-rickets faculty of Vitamin D is not dependent solely upon the substance supplied in the oil or in the food. It appears that in order for Vitamin D to exert its full effect, the influence of ultra-violet light is necessary. Quite recently it was discovered that many foods ordinarily incapable of exerting anti-rachitic properties were found to do so after exposure to ultra-violet rays. Moreover, animals fed on a rickets-producing diet could be kept free of this disease if they were subjected to the action of ultra-violet light or sunshine. It is obvious, therefore, that something is present in certain foods and in the bodies of animals which when acted upon by ultra-violet radiations produces Vitamin D. This "something" has been traced and is now recognised to be a fat-like substance known as ergosterol. Irradiated ergosterol, the active principle of cod liver oil, is sold under the name Viosterol, which contains one hundred times the Vitamin D content of cod liver oil. The advantages of this concentrated preparation of Vitamin D are that its potency can be standardised and that only very small doses are necessary—drops instead of the usual teaspoonfuls. Very often an excess of something which is beneficial results in harm rather than good. Over-dosage with a concentrated Vitamin D product may give rise to a condition called hyper-vitaminosis.

Vitamin E is the reproduction vitamin. In experimental animals, lack of Vitamin E results in sterility, or, in the event of pregnancy taking place, the foetus fails to develop properly. Vitamin E is present in wheat germ, green vegetables, egg yolk, liver and some vegetable oils.

Pathological conditions resulting from an absence of vitamins are known as deficiency diseases. These can be produced readily in animals by arranging diets deficient in the respective vitamins. One might gather from inferences suggested in certain types of current literature that deficiency diseases were a scourge upon our modern civilisation. How many of us have seen a typical case of scurvy, beri-beri, pellagra or rickets in an adult Canadian? One must admit that these conditions are rare under the conditions of life enjoyed by the majority of the population of our country. A distinction must rightly be made between shortage or lack of, and deficiency or absence of vitamins. It is quite possible that abnormalities of function and structure may result from slight but continuous lack of the various vitamins.

An adequate supply of vitamins, particularly A, C, and D, is especially necessary during infancy and childhood, when bones, teeth and other tissues are being formed and exposure to infections is common. Not only does the expectant and nursing mother require vitamins to provide for her own needs, but she must be prepared to pass on a liberal supply to her offspring, both before birth and during the nursing period.

That, briefly, is the story of the vitamins. Wonderful as they are, there is no just cause at present for ascribing to their lack all the ills, from colds to cancer, to which the human race is heir.

Principles of Diet in Health

From what has been mentioned above, the principles of diet in health are simple. The daily food should contain an amount of energy at least equivalent in calories to the energy expended by the body. A certain minimum of protein is essential. Nature provides all the necessary vitamins as well as mineral salts and roughage in readily available form in various natural food products. The advisability of a balanced, mixed diet containing fresh fruits and green vegetables is obvious. Excess of any desirable thing is a potential source of harm. This is to say, a diet too high in calories or containing an over-abundance of carbohydrate, fat, protein or salt may give rise to pathological conditions. Under ordinary circumstances, there should be no necessity for recourse to special preparations of vitamins, since only very small quantities of these are required for protection. But when disease due to vitamin deficiency exists, the therapeutic use of special vitamin-containing products is advocated, or when shortage of vitamins is threatened by refusal of a child to eat sufficient of the desirable articles of food, an adequate supply of vitamins can be assured by providing reliable vitamin-rich products. (Continued in July)

The Ten-Hour Day for Vancouver Nurses

By OLIVE V. COTSWORTH, Convener, Private Duty Section, British Columbia Graduate Nurses Association

During the past two or three years the members of the Vancouver Graduate Nurses Association have been discussing shorter hours for private duty nurses, and so it was after much planning and reasoning that it was decided to begin a ten-hour day, starting on April 1st of this year, 1930.

Planning a shorter day for nurses is not like planning an eight-hour day for plumbers, or school teachers, or even public health workers. The human element involved makes it a much harder task to plan the day to suit all concerned.

It was felt, however, that the majority of cases could do with a nurse on ten-hour duty. Serious cases, requiring private duty nurses, or post-operative cases, would probably require 12-hour duty, therefore, to fill this demand twelve-hour duty might be done at a fee of $6.00 per twelve-hour day. This is not considered exorbitant, as in reality it is only 50 cents an hour, and it is generally known that one cannot get trained or skilled workers in other professions at this low rate.

The purpose of the increase was not higher fees, but was made as the means of drawing a definite line between ten and twelve hour duty. The schedule of ordinary fees in Vancouver is arranged on this 50c an hour basis: 10-hour, $5.00; 12-hour, $6.00; 24-hour duty, really 14-hour, $7.00.

The day has been divided into 7—7 or 8—8 hour duty for 12 hours, and 8—6 duty, day or night, 10 hours. The two hours in the early a.m. or p.m. when the patient is alone, the ordinary nursing service in the hospital is available, or in case of the home, the family share in the care of the patient.

This, it is believed, is all to the good, as the family and hospital will probably take more interest in the individual patient's progress.

As there are often nurses on night duty alone, if advisable the night nurse may work 9 p.m.—7 a.m., so that the patient is made comfortable for the night, and day also.

As regards the meals for the nurse, it has been arranged that the nurses on 12 hours are entitled to three meals. The nurses on 10 hours are, however, only entitled to two meals a day, and may arrange to take any meal they like, outside of the mid-hour meal, at home.

Although the ten-hour day is new in Vancouver, it is believed that it is feasible and will work at least until a change comes that will make for still further improvement. The hospitals have helped the nurses tremendously in their new hours. The patients, always the primary interest, have fallen in with the request in a wonderful spirit of co-operation. The medical profession—many have proved themselves as always the nurses' best friends, others are slow and some criticise their action. However, when the doctors fully realise what it means to the nurses, and that their patients will still have the best of care, it is felt that the medical profession will come up to the top, and help the nurses as they always have. A good many of the medical men really have not the full knowledge of the working of the ten-hour day. A good many have said that they thought it was a poor time to make the change. The nurses feel, however, that even though times are poor for private duty nurses, it is a good time to make the change, as people will realise that it is the ten-hour day the nurses need instead of the extra fee, which, if brought in when there was a scarcity of nurses might create more criticism still.

It has not been found nor is it anticipated that curtailment of the hours will lessen the demand for private duty nurses in Vancouver; also the nurses do not hesitate to state that should the Commission, or Survey, find any better answer to the question for shorter hours, a change for the better will always be in order.

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Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
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The Municipal Doctor Scheme in Saskatchewan

By F. C. MIDDLETON, M.D., D.P.H., Deputy Minister of Public Health

The Province of Saskatchewan has a population of 866,700 scattered over an area of 251,700 square miles! 14.4% of the people reside in the 8 cities; 7.7% in the 80 towns; 8.4% in the 377 villages, and 65.3% in the 301 organised rural municipalities; and in addition 2.9% reside in unorganised territory, and 1.3% are Indians on the reserves. Over three-quarters of the population might be considered as rural residents. To provide adequate medical and nursing service, especially to these rural sections of the province, has been one of the many problems to be solved by the people.

The natural tendency for both doctors and nurses is to drift to the larger centres where there are hospital facilities, where there are living conveniences such as those found in cities and towns, and where there are better educational facilities for children. With a sparse population in many districts the amount of professional work for a doctor or nurse is not sufficient to warrant them remaining in such district, and, of course, coupled with this is the comparatively high expense and great inconvenience to individuals when sickness occurs, in bringing a doctor or nurse from long distances.

Co-operative schemes having been tried out in this province in many other lines with a good deal of success, it was thought that a co-operative scheme to meet the requirements for supplying doctors and nurses might also be worked out, with the result that permissive legislation was asked for, allowing the rural municipal councils to engage the services of a doctor or nurse for the municipality. The necessary legislation was therefore placed in the Rural Municipality Act as follows:

Grants to Physicians: The Rural Municipality Act, chapter 34, section 173, subsection (38), of 1928-29, provides that the council of every municipality shall pass such by-laws as it may deem expedient for the purpose of making an annual or other grant to a legally qualified medical practitioner resident in the municipality as an inducement to such practitioner to reside and practise his profession within the municipality, or guaranteeing the income of such practitioner in consideration of his residing and practising his profession within the municipality, no such grant to exceed $1,500.00 per annum and no such guarantee to exceed the amount required to bring such income up to $1,500 per annum.

In case there is no urban centre in such municipality, the grant or guarantee might be given to a doctor residing in a village in an adjoining municipality.

When such a grant is given to a physician, the primary purpose is to ensure that a doctor is located within a reasonable distance, and the agreements as to what professional services will be required for the grant vary considerably. In practically all cases the doctor is required to do the Medical Health Officer duties, and to give free medical services to indigent cases within the municipality; in some cases mileage charges are reduced, and in some reduced charges are made for maternity cases.

Some thirteen Rural Municipal Councils pay grants varying from $900.00 to $1,500.00 a year.

Engaging a Physician: The Rural Municipality Act, chapter 34, section 174, 1928-29, provides that the council may submit to the electors a by-law empowering the council to engage the services of a legally qualified medical practitioner for the municipality at a salary not to exceed $5,000.00 per annum. If twenty-five resident ratepayers petition the council to submit such by-law to the electors, the council must do so, and after the by-law has passed, if twenty-five per cent. of the resident ratepayers request that the by-law be repealed the council must submit a repealing by-law to be voted on by the electors.

When a municipality has voted to engage the services of a municipal doctor, the council draws up a written agreement outlining what services the doctor shall give to the people. The agreement usually requires: that the municipal doctor act as medical health officer; that all indigent cases within the municipality be given free medical care; that all resident ratepayers, their families and dependents be given free medical service, and in some municipalities hired help is included in the free service and such other residents as the agreement may call for. Free vaccination against smallpox and inoculation against diphtheria for both pre-school and school children is included, and in some municipalities the doctor is required to medically examine all the school children in the municipality once a year.

Nineteen municipalities have engaged municipal doctors, several others have passed the necessary by-law, and more are considering the same. Invariably where one municipality has engaged a municipal doctor, the adjacent municipality is not long before it also engages a municipal doctor, so that they appear on the map in groups of twos and threes adjoining one another.

The salary paid varies from $3,500.00 to $5,000.00 a year according to the district. Based on $5,000.00 a year it costs about $3.85 taxation per quarter section (160 acres) per year for medical service.

A rural municipality is an area 18 miles square, so that a doctor located about the centre would be within reasonable distance of all his patients.

In one municipality where a municipal doctor has been engaged for a number of years, the municipal council also pays for the services of a nurse for any of its ratepayers for a period of fifteen days in any one year, when in the opinion of the doctor a nurse is required. A nurse is supplied at the expense of the council for all normal maternity cases for nine days, and longer if the doctor thinks it necessary. The nursing service under this arrangement cost this municipality in 1928 $2,053.00. This municipality has a population of 1,350. Taking a period of six years—1923-1928, inclusive—there were in that municipality 185 births with no maternal deaths. There were 25 deaths from all causes in the six years, representing an average death rate of 3.3 per 1,000 population. Twelve of the twenty-five deaths were as follows: One drowning; one fractured skull; one intussusception; one infant found dead on railway tracks; one suicide; one accidental scalding; one aged 69; two aged 70; one 74; one 78, and one 80; all of which might be considered uncontrollable. There were nine died under one year of age, so that the infant mortality rate was 48.7 per 1,000 living births. There was not one death from a communicable disease in the six years.

The success or failure of the municipal doctor scheme depends largely on the doctor employed. Financially the doctor is much better off because he has no bad debts; from a public health viewpoint this system next approaches the full-time health unit, and the fact that not one municipality which has ever tried the scheme has repealed the by-law is evidence that it is satisfactory to the people.

The Relationship of the Visiting Nurse to the Medical Profession

By ETHEL CRYDERMAN, Central Supervisor, Victorian Order of Nurses for Canada

I have been asked to speak briefly on the relationship of the visiting nurse to the medical profession. It is rather singular to note that although the observance of professional etiquette is one of the fundamental principles in public health nursing, comparatively little has been written other than generalities on this subject. That it is of vital importance is recognised, and that it is probably the greatest contributing factor in the permanently successful construction of any public health organisation is unquestionable. Professional etiquette is a much quoted and misinterpreted term, and the fact that the observance of it applies equally as much to the medical profession as to the nursing profession is not always recognised. Probably the word relationship which is synonymous and is more generally used today has for many a more practical meaning. Miss Gardner defines professional etiquette as "the relation of the medical and nursing professions to public health work and to each other," and here not only the importance of the close co-operation between the two professions but the significance of the sharing in the observance of this principle can be sensed.

In considering this relationship, and today the part of the nurse can play in its development will be especially emphasised, the following factors seem to be of paramount importance.

1. *The Recognition of the Leadership of the Medical Profession.*

In speaking of the public health nurse's part in ante-natal work, Miss Van Blarcom says: "The nurse must appreciate the fact that every detail of maternity work originates in and is guided by the medical profession." In all phases of public health work this is equally as true, and the nurse's realisation of this is the keynote in promoting a good relationship. With the broader-minded, modern, public-spirited doctor, who recognises the public health nurse as a co-worker, the nurse is very conscious of her dependence upon the medical profession. But with the physician who refuses to co-operate and where the work is definitely retarded on account of the attitude of a member of the medical profession the public health nurse is faced with a problem that is not easily solved. When the medical profession, as a group, is considered, our dependence upon them is easily recognised, but our individual relationships with doctors frequently present grave difficulties.

It is necessary to remember when applying a general principle that individual personalities cannot be considered and that constantly the interpretation of leadership in the broader sense is essential. The vitally important thing is to be convinced of the leadership of the medical profession and to recognise it under all circumstances.

2. *The Value of Observing Professional Etiquette.*

From the beginning the value of establishing a good relationship with the medical profession has been stressed. That doctors have been in the majority in assisting to establish such a relationship has been proved by the growth of public health work within the last few years. The team play that is frequently seen today is significant and can be attributed to the development of this co-operation between these two professional groups. In spite of the lack of response on the part of a doctor, a nurse must continue to observe professional etiquette and even though difficult she must use her influence in stimulating a good relationship. Frequently through good service and tolerance she creates a demand for her services, and the doctor who pre-

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(Read before a Joint Conference of Metropolitan Life Insurance Company and Victorian Order supervisors in July, 1929.)

viously refused to co-operate becomes convinced of her value, not only to his patients but to the community as a whole. Often this development is slow, but a nurse's inability to understand a doctor's attitude is never an excuse for the non-observance of a fundamental principle.

3. *The Necessity to Interpret a Good Relationship Correctly.*

Occasionally nurses interpret the establishing of a good relationship incorrectly. This does not refer to following prescribed orders, but rather in nurses assuming responsibilities that are not legitimately theirs but which have been requested by doctors. All organisations have rules and regulations, and although a nurse is given considerable latitude it is wise, within certain limitations of course, to follow these rules. For instance, doctors occasionally ask nurses to give anaesthetics, to remain with obstetrical cases and call them when necessary, etc. Unquestionably a response to these requests establishes temporarily a good relationship, but it also may establish a wrong precedent, and frequently a new nurse who realises this has difficulty in convincing doctors that her services are being misused. Establishing a relationship on a wrong basis is detrimental and inevitably presents difficulties.

In considering this question of relationship, these three factors, *i.e.*, the recognition of the leadership of the medical profession, the value of observing professional etiquette and the necessity of interpreting a good relationship correctly seem to be the general principles which govern the establishing of a satisfactory relationship with the medical profession.

There are many practical points which help to promote such a relationship, and the following which will be touched upon very briefly may help to serve as a basis for discussion.

(1) There can be no question that the relationship with the Medical Officer of Health is of paramount importance. His support of the work is essential and this can only be secured through the closest co-operation with him.

(2) The necessity for local boards to have either an advisory medical committee or a medical representative appointed by the local Medical Association to act as their representative at board meetings and to report back to them is apparent. The advisory medical committee or the medical representative to whom all medical problems can be referred not only facilitates matters greatly for the nurse but stimulates interest and promotes co-operation in the local health project.

(3) The value of submitting tentative standing orders to local men for approval and further suggestion cannot be over emphasised. After discussion and approval, their signature not only safeguards the nurse but clearly defines her latitude in terms of the medical profession.

(4) The principle of facing difficulties which arise with the medical profession is a wise one. It is fatal to allow discontent to smoulder, and doctors appreciate candidness. Frequently misunderstandings which might have led to grave difficulties have been cleared up instantly.

(5) The realisation on the part of the nurse that a family doctor, on account of his intimate knowledge of a family, can be invaluable, if consulted, in helping to understand a family problem, is important.

(6) The well-known rule of nurses not continuing to attend a patient without a doctor in attendance, the wisdom of withdrawing if a doctor so desires, and the desirability of a nurse using her influence to strengthen the position of the physician in the home scarcely need to be mentioned.

(7) The advantages of a loyal but impersonal relationship with doctors and the wisdom of treating all alike regardless of ability or personality cannot be too strongly emphasized.

(8) That a nurse in a new district should visit each doctor personally and interpret to them the work and the procedure of her organisation is most desirable. (Concluded on page 322)

News Notes

The Fifteenth General Meeting of the Canadian Nurses Association opens in Hotel Saskatchewan, Regina, at 2 p.m., on Tuesday, June 24th, 1930. From then until Saturday, June 28th, general business sessions, Section meetings and Round-Tables will be held every day. Tuesday evening, the visiting nurses are to be the guests of the Saskatchewan Registered Nurses Association at a dinner which is to be preceeded by a reception at 6.30 p.m. Dr. George M. Weir, Director of the Survey on Nursing Education in Canada is to speak on "The Nurse and the Public."

On Wednesday evening addresses are to be given by Dr. Edith Bryan, Assistant Professor of Public Health Nursing, University of California. Miss Ethel Johns, Director of Studies for the Committee on Nursing Organisation of New York Hospital, and Dr. George M. Weir.

Thursday evening is given over to the showing of several films relative to nursing and allied interests, while Friday evening is being left free so that various committees, Alumnaes, etc., may be able to arrange for dinners, re-unions and meetings.

The members of the Saskatchewan Registered Nurses Association have been very busy for months past with their preparations to make the first meeting of the Canadian Nurses Association held in Saskatchewan a decided success.

For the first time the C.N.A. is undertaking the showing of Commercial Exhibits. From reports it seems that this department as well as the Educational Exhibits shall prove very attractive to everyone.

Nurses who have not made reservation for accommodation at the Hotel Saskatchewan, are advised to do so immediately. The management has arranged to provide splendid accommodation for everyone. The rates are:

Single Room-----$4.50 o $5.50 per day.
Double Room----$8.00 to $9.00 per day.

It has already been announced that after consulting with the Canadian Passenger Association it was decided inadvisable to arrange transportation according to the Validated Certificate Plan. The Regular Summer Tourist rates are more advantageous, especially for those who are planning post-convention tours to Eastern or Western Canada. Nurses who are planning to attend the General Meeting are advised to consult the nearest passenger agent for these rates.

Nomination Slate, 1930

For President

Miss Florence H. M. Emory, Assistant Director, Department of Nursing, University of Toronto, Toronto.

For First Vice-President

Miss Elizabeth L. Smellie, Chief Superintendent, Victorian Order of Nurses for Canada, Ottawa.

Miss Kathleen W. Ellis, Vancouver.

For Second Vice-President

Miss Gertrude Bennett, Superintendent of Nurses, Ottawa Civic Hospital, Ottawa.

For Honorary Secretary

Miss Edith B. Hurley, Director of Nursing, University of Montreal, Montreal.

Miss Nora Moore, Assistant Director, Division of Public Health Nursing, Department of Health, Toronto.

For Honorary Treasurer

Miss Ruby M. Simpson, Director of Nursing Services, Department of Public Health of Saskatchewan, Regina.

ALBERTA

Calgary: The Calgary Association of Graduate Nurses held a luncheon in the Board of Trade Rooms on April 12th, at which Miss Pansy Pue, one of the City aldermen, addressed the nurses on Citizenship. Both the address and luncheon were enjoyed by a large number of local nurses.

Edmonton: The Graduation Exercises of the School of Nursing, Royal Alexandra Hospital, took place on April 11th in the Nurses Home. His Honour the Lieutenant-Governor, Dr. W. Egbert, presented the diplomas and badges.

The prizes presented by Mayor J. M. Douglas were awarded to Miss Helen Keeling, gold medal; Miss Ruth Keeling, silver medal; Miss H. Keeling, General Proficiency; Miss Tracey, Medicine and Infectious Diseases; Miss Jones, Surgery and Obstetrics; Miss H. Keeling was also awarded the Crowe Scholarship for this year.

The new wing of the Royal Alexandra Hospital is now open. Miss Mona English has been added to the staff of the Children's Department.

Miss Henderson (1929), has accepted a position in the Hanna Hospital (Alberta); Miss Priem (1930), has accepted a position in the Cold Lake Hospital (Alberta); Miss Evelyn Seddon is visiting her home in the old country, and Miss Einarson has been temporarily appointed to her position.

Medicine Hat: The Graduation Exercises of the Medicine Hat Training School for Nurses were held in the Fifth Avenue United Church on May 1st. Dean Howes, of Edmonton University, gave the address to the graduation class. Mr. Beveridge, President of the Hospital Board, presented the diplomas. Special prizes were given to Miss A. Carleton, for Ethics and Practical Work; Miss J. Robertson, for Surgery and General Proficiency; Miss J. Jorgenson, for Obstetrics: these awards were presented by Mayor Bullivant. Dr. MacCharles administered the Nightingale Pledge to the graduating class.

On the following evening a reception and dance were held when the guests were received by Miss Auger, superintendent of nurses.

The regular meeting of the Medicine Hat Graduate Nurses Association was held at the home of the president, Mrs. D. M. Smith, on May 6th. A pleasant social hour and refreshments followed the business part.

BRITISH COLUMBIA

The annual meeting of the Graduate Nurses Association of British Columbia was held in Victoria, at the Empress Hotel and the Provincial Royal Jubilee Hospital, on April 21st and 22nd, with Miss Mary Campbell in the chair.

On the morning of the 21st, business meetings were held by the three sections: Public Health Nursing, with the convener, Miss E. G. Breeze, in the chair; Nursing Education, with Miss Mabel Gray as convener; and Private Duty Nursing, with Miss O. Cotsworth as convener.

At 2 p.m. the conference began by the Rev. C. S. Quainton, Dean of Columbia, offering the invocation. The President's address was given by Miss Mary Campbell, followed by the minutes of the general meeting. The Registrar's report was read by Miss Helen Randal, and the Secretary's report by Miss Mabel Dutton. Then the reports of the Standing Committees were given. From 4 p.m. to 5 p.m. the delegates visited St. Joseph's Hospital, and went over the new Nurses Home, which was very much admired. Tea was served by the Mother Superior and Sisters.

At 8 p.m. a banquet was held at the Empress Hotel, the speaker being Miss Helen Stewart. Miss Stewart, who is making a survey of the Fraser Valley for the Carnegie Library Fund, to see how libraries can be established and maintained in this district, gave a most interesting address on the value and necessity of the library to all members of the community, and went into the history of libraries and why they were established.

On Tuesday, April 22nd, the conference started at 8 o'clock with a drive and visit to Queen Alexandra Solarium at Mill Bay. The visitors were welcomed by Dr. Cyril Wace, Medical Superintendent, and Miss Stone, the Matron, and were shown over the wards and the new home for the nurses, all of which aroused the very warmest admiration, and much interest was shown in the splendid work being carried on by the Institution. The members of the conference then drove back to Victoria over the Malahat, stopping at "Look-Out" on the Malahat for lunch.

At 2 p.m. there was a joint meeting of the three Sections. Miss Grace Fairley, of the Nursing Education Section, spoke very forcibly of the increasing demands which must be met and how there will have to be a re-adjustment of the curriculum in most of the schools of nursing. The address met with great attention, and was enthusiastically received. Then Miss Margaret Kerr, of the Public Health Nursing Section, spoke on the topic of "Here and There in Public Health." She gave a very graphic description of the centres which she visited during the period when she was studying under the Rockefeller Foundation Scholarship, at Columbia University. Miss Ethel Thornley, of the Private Duty Nursing Section, spoke on "Every Nurse a Public Health Nurse," and gave a very interesting paper. After the meeting, afternoon tea was served by the Provincial Royal Jubilee Hospital Alumnae Association.

At 8 p.m. a musical programme was given and two addresses, the first by Dr. A. R. Chisholm, on "Recent Measures of Prevention" and the second by Dr. Russell Roberts on "Ante-Partum Care During Pregnancy."

Unfinished business was then discussed, and voting for the election of delegates to the Biennial Meeting of the Canadian Nurses Association at Regina took place, and the following were elected: Miss Mary Campbell, the President, representing the Public Health Nursing Section; Miss O. Cotsworth, representing the Private Duty Section; and Miss Curry, respresenting the Educational Section. These delegates will vote on various questions with regard to the Canadian Nurses Association, and also will pay special attention to the survey of nursing now in progress in Canada. The meeting passed a resolution to the effect that the British Columbia delegates to the Biennial Conference are to be instructed to vote in favour of further money being raised for the continuance of the Survey, if necessary, so that a complete report can be obtained. A very warm discussion took place on dual affiliation, but no decision was arrived at.

The British Columbia Graduate Nurses' Association brought up the question as to whether it would not be advisable to reduce the number of meetings held during the year, and a motion was made that, instead of holding three meetings as formerly, two meetings would be held—the annual meeting always being on Easter Monday, and the other meeting being arranged as suitable.

When Miss Elizabeth L. Smellie, the Chairman of the Public Health Section of the Canadian Nurses Association, and Chief Superintendent of the Victorian Order of Nurses, was in Vancouver, the Public Health Section of the City Association gave a dinner in her honour, at the Grosvenor Hotel, Miss E. G. Breeze presiding. About sixty nurses attended. Miss Smellie gave a most interesting talk on The Nurse in Public Health, and also on what she found of interest in other parts of Canada when travelling through, which she thought would be of benefit to the nurses of B.C. Miss Smellie was presented with a bouquet of roses and was very enthusiastically thanked for her talk.

At a recent meeting of the Vancouver Graduate Nurses Association, an interesting visitor and speaker was Miss Anita Jones, B.S., Assistant Director of the Maternity Centre Association of New York.

Miss Jones spoke on the work of the Association, stating that the two main objects are to teach the public the vital importance of adequate maternity care, and to secure in co-operation with all existing agencies, such care for expectant mothers. After the meeting a reception was held and refreshments served.

General Hospital, Vancouver: On May 6th, the Alumnae held an informal and enjoyable party for the members of the Graduating Class 1930. The entertainment took the form of a Country Fair, with the majority in attendance in fancy dress costume. Miss Margaret Kerr, of the University of British Columbia, gave a short address, urging the new members to keep in touch with their Alumnae. Miss Cotsworth extended a hearty welcome to the new members.

Miss Edna McVicar has been appointed superintendent of the Vernon Jubilee Hospital, to succeed Miss Bessie Clark, who is leaving Vernon in June to accept a similar position at the Royal Columbian Hospital, New Westminster.

Mrs. Ethel Walsh (1917), her daughter Muriel and her mother, Mrs. Scarlett, were all severely bruised in a recent motor accident, near Tacoma, Wash. It is hoped that they will soon recover

MANITOBA

Winnipeg: The quarterly supper meeting of the Manitoba Association of Registered Nurses was held in the Blue Kitchen, Winnipeg, on April 22nd. Miss Hilda Hesson, the guest speaker, gave an interesting and descriptive talk on the British Isles and Continent.

Four official delegates were appointed to attend the Canadian Nurses Association General Meeting to be held in Regina in June.

Mrs. Stella Gordon Kerr was appointed recording and corresponding secretary and treasurer, also registrar for the Association.

The office of the M.A.R.N. will continue to be at 753 Wolseley Avenue, Winnipeg.

The following local Schools of Nursing held Graduation Exercises during the month of May. The exercises were preceded by a number of social events arranged for the graduates of each school: Misericordia Hospital, Winnipeg; General Hospital, Winnipeg, and St. Boniface Hospital.

Brandon: Graduation exercises at the Brandon General Hospital were held on May 15th in St. Paul's Church, when a class of twenty received diplomas.

NEW BRUNSWICK

Chipman Memorial Hospital, Saint Stephen: The Alumnae held a successful food sale in March at which the sum of $96.00 was realised.

The student nurses of the Hospital are most grateful to their Instructor, Miss Florence Cunningham, for the gift of new class-room chairs.

The February meeting of the local Chapter met at the home of Mrs. Walter McWha, and the April meeting at Miss McMullen's. Both of these meetings were well attended. After the business meeting refreshments were served and an hour's entertainment enjoyed.

Miss Inez Holt has returned after having spent four years in Cleveland, Ohio, and is now doing private duty nursing in Saint Stephen; Miss Jessie Sansom has gone to New York to engage in private work; Miss Estelle Murphy is convalescing in Woodland, Maine, after a serious operation.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse," for Ontario, in May, 1930, were 1,208. Thirty-one less than in April, 1930.

Appointments

Miss Kathleen Twiss (Toronto General Hospital, 1925), night supervisor at Burnside; Miss Muriel Miller (Toronto General Hospital, 1928), assistant on Ward F, Toronto General Hospital. The following appointments have been made to the New Pavilion of Toronto General Hospital: Miss Sylvia Osler (1922), charge of the Admitting Department (day duty); Miss Dorothy Harstone (1918), charge of Admitting Department (night duty); Miss Effie Fergie (1920), charge of surgical supplies and ward helpers; Miss Margaret Mable (1928), relief nurse for night executive staff; Mrs. Lindsay (1917), supervisor of obstetrical services; Miss Heggie (1926), head nurse on eighth floor; Miss Ruth Young (1924) and Miss Margaret Turnbull (1929), operating room staff, day duty; Miss Ruth Hunter (1929), night duty in the operating room; Miss Jean Templeton (1925) and Miss Hildred Young (1928), day duty on labour room staff; Miss Sadie Williams (1926), night supervisor in labour room; the newly-appointed general duty nurses are Miss Alice Orchard (1922), Miss Jean Gates (1925), Miss Marian Cress (1925), Miss Isobel McLaren (1928), Miss Beatrice Bovair (1929), Miss Helen Lollis (1929), Miss Molly Rowe (1929), Miss Margaret Keir (1929), Miss Janet Haggert (1930), Miss Jessie Cameron (1930), Miss Bernice Brown (1930), Miss Margaret Bonter (1930), Miss Jean L. Clemens (1930), all graduates of Toronto General Hospital; also Miss Ila Jones (Victoria Hospital, London, Ont., 1925), Miss Mary F. Thomson (Grace Hospital, Detroit, Mich., 1926), Miss Marguerite Jackson (Hospital for Sick Children, 1929).

Miss Margaret Zimmerman has joined the staff of Brantford General Hospital, taking Miss M. McCormick's position as supervisor of Private Patients' Department; Miss Esther Cunningham (Toronto Western Hospital, 1919), in charge of the Red Cross Hospital, Dryden, Ont.; Miss Elaine Playle (T.G.H., 1928), the operating room, Toronto Western Hospital; Miss Fanny Arnott (T.W.H., 1920), the Red Cross Hospital, Bracebridge, Ont.; Miss Lillian Hinton (Oshawa General Hospital, 1928), the obstetrical staff of the Toronto East General Hospital.

The fifth annual meeting of the Registered Nurses Association of Ontario, which was held at the Royal York Hotel, Toronto, from Thursday, April 24th to Saturday, April 26th, was attended by more than 500 nurses. The invocation and addresses of welcome were given by the Rev. Trevor Davies, Rev. Father John Burke and Controller Robbins at the opening session on Thursday. General business sessions were held Thursday morning and afternoon and Saturday afternoon. The three Sections held their business sessions simultaneously on Friday morning, followed by discussions which were held concurrently and which were open to the other Sections:

1. Nursing Education—Round Table Conference on Common Problems;
2. Private Duty—"Some Obstetrical Problems," led by Dr. Van Wyck;
3. Public Health—"The Nursing of Communicable Diseases in the Home," led by Dr. Beverley Hannah and Miss Marion Nash.

In place of the usual open meeting on Thursday evening, a meeting confined to nurses was held, and was devoted to a symposium on Nursing Services from the Standpoint of the Public, Mrs. H. P. Plumptre; The Hospital, Mr. Fraser Armstrong, Kingston General Hospital; The Physician, Dr. G. Harvey Agnew, Secretary Canadian Medical Association; The Public Health, Dr. G. P. Jackson, M.O.H., Toronto; The Nurse, Miss Isabel MacIntosh. This was a most illuminating meeting, and was felt to be much worth-while.

On Thursday afternoon the Central Registry gave a luncheon for the Board of Directors, Committee Chairmen, etc. That afternoon District 5 was hostess at tea to the whole Association. On Friday the Robert Simpson Co. gave a tea for the Board of Directors and the non-Toronto members, and in the evening Dr. George Locke was the entertaining and inspiring speaker at the banquet.

District 2

General Hospital, Brantford: Miss Nellie Yardley attended the R.N.A.O. Annual Convention in Toronto in the capacity of Brantford representative; others attending that Convention were the Supervisors of the General Hospital, Misses Helen Ton and J. Wilson (Assistant Superintendent). Miss M. McCormick has left to assume her new position as Assistant Superintendent at the Cobourg Hospital; her departure was regretted by all.

District 5

General Hospital, Toronto: The New Pavilion and Hospital extensions were officially opened on April 24th, 1930, by the Lieutenant-Governor, the Hon. W. D. Ross, LL.D. Following his address, short addresses were given by the Hon. G. Howard Ferguson, Mayor Wemp, Sir Robert Falconer and Mr. C. S. Blackwell. Canon Cody unveiled and presented to the Hospital the portraits of the following: Messrs. James Worts, G. H. Gooderham, D. A. Dunlop, C. S. Blackwell, Sir Joseph Flavelle, and Sir John Eaton, all of whom have been vitally interested in the welfare of the Hospital. These were accepted by Mr. Blackwell, the President of the Board of Directors. The building was then opened to the guests for inspection, and tea was served in the Nurses' Cafeteria.

Miss Williams has resigned as Night Supervisor at Burnside.

Western Hospital, Toronto: Dr. W. E. Ogden gave an instructive lecture on Tuberculosis at the April meeting of the Alumnae. Miss Ruth MacLean (1926), is doing private duty nursing in Norfolk, Virginia, U.S.A.

Oshawa: At the regular monthly meeting of the Alumnae Association of the Oshawa General Hospital, held at the Nurses Residence, on April 7th, Dr. Grant L. Bird gave a very interesting and instructive address on "Diabetes, Its Causes, Symptoms and Treatment," which was very much enjoyed by the large number of nurses present.

A student graduate of the University of Toronto Public Health Course, spent the month of May in field work experience with the Department of Health, Oshawa.

QUEBEC

General Hospital, Montreal: The following appointments have been made recently—Miss Doherty (1930), in charge Ward X where she succeeds Miss Grace Carter; Miss Kirkham, with the Child Welfare Association, Montreal; Miss Vera McLeod, to the Arvida Hospital, Arvida, P.Q.; Miss Hattie Elliott, first aid nurse with the Construction Camp at Montebello, P.Q.; and Miss Olive Mulligan, to Hartford General Hospital, Hartford, Conn.

Recently Miss L. Davis, Operating Room Supervisor, spent ten days with Mrs. H. Cleveland (Louise McLeod), Torrington, Conn.

Miss Grace Carter, who recently resigned as charge nurse of Ward X, will spend the summer abroad.

Owing to illness in her family Miss F. E. Strumm, First Assistant to Miss Holt, has been granted three months leave of absence.

Miss M. Armstrong, Mrs. Marlett and Mrs. LeGrand have been ill in hospital recently.

Royal Victoria Hospital, Montreal: Miss Milla MacClelland and Miss Helen Sharpe left recently for Jasper Park Lodge, Jasper, Alta., where they have been engaged for the summer by the Canadian National Railways. Miss Sharpe attended the School for Graduate Nurses, McGill University, during the past year. Miss Helen Buck, Superintendent of Sherbrooke Hospital, Sherbrooke, Que., is spending some time abroad.

Western Hospital, Montreal: Miss A. M. McQuat was elected as the representative of the Alumnae to attend the General Meeting, C.N.A., in Regina.

Miss Nelson (1898), has been a patient in this hospital, with a fractured arm for the past few weeks.

Miss Elizabeth Wright, who has been a patient in The Montreal General Hospital, is progressing favourably.

The engagement is announced of Miss Marjorie Macfarlane (1928), to Mr. F. Bradshaw, of London, England.

SASKATCHEWAN

Grey Nuns Hospital, Regina: The meeting of the Alumnae was held at St. Chad's College. Business discussed was the holding of a rummage sale, but a definite date was not fixed on account of scarcity of material. After the meeting the members were entertained by Miss I. Irons, and a pleasant evening spent.

Moose Jaw: The Registered Nurses Association of Moose Jaw, and the nursing profession generally have suffered a very severe loss in the death of Mrs F. C. Harwood who passed away suddenly at her home in Moose Jaw, on March 20th, 1930.

Mrs. Harwood (nee Jennie Galbraith), was a graduate of Prospect Heights Hospital, Brooklyn, N.Y.

Although not actively engaged in nursing for some years, Mrs. Harwood had always maintained a keen interest in the nursing profession, and was always actively interested in the improvement of conditions and standards of the profession. She held various offices on the Executive of the Registered Nurses Association, and at the time of her death was Advisory President.

The local Association depended a very great deal upon Mrs. Harwood. She was always present with reliable advice, active support and a cheerful word of encouragement.

General Hospital, Moose Jaw: Miss Rose Drewery (1929), has just accepted a position on the Shaunavon Hospital staff after spending three months vacation in Hollywood, Calif.; Miss J. M. Powell (1929), is relieving Miss R. Hansen (Lloydminster Hospital), the latter being called home owing to the illness of her mother; Miss Hilda Hill (1929), has charge of the Lloydminster Hospital operating room; Miss Edith Morrow (1929), has accepted a position on the staff of the Arcola Hospital; Miss Alberta Aldcorn (1922), is visiting relatives in Toronto.

Providence Hospital, Moose Jaw: The regular monthly meeting of the M.J.R.N.A. for June will be held in the Lecture Room of Providence Hospital. The 1930 Graduating Exercises will take place in St. Joseph's Hall on Thursday, June 19th. On this occasion twelve nurses will receive their diplomas. Word has been received that the nurses who wrote their examination for Registration in January were all successful.

Miss Edna Martin and Miss Eva Munroe, of the recent Graduating Class, have gone to Watertown, N.Y. They have accepted positions in the Good Samaritan Hospital there. Miss Mary Griffith has accepted a position on the staff of the Fort San Sanatorium, where she is taking a post-graduate course; Miss Wheeler (1922), left early in March for Los Angeles to resume her position in the Good Samaritan Hospital, whence she had been called owing to the death of her father. The friends of Miss Eva Cousins will be sorry to hear that she has been seriously ill in the hospital for the past two months. Miss K. Lott (Shaunavon, Sask.), spent Easter with her parents in Moose Jaw.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BARTLETT—In March, 1930, to Mr. and Mrs. Bartlett (Una Phelan, Western Division, Montreal General Hospital), a daughter.

BEALE—On March 5th, 1930, to Dr. and Mrs. Frank Beale (Madeline Payne, Western Division, Montreal General Hospital), a daughter.

CROSBY—On April 11th, 1930, at Toronto, to Mr. and Mrs. C. Crosby (Lorine Lowrie, Toronto General Hospital, 1922), a son.

GLEDHILL—On April 25th, 1930, at Toronto, to Mr. and Mrs. T. L. Gledhill, (Helen Blair, Toronto General Hospitall 1921), a son.

HARLAND—On March 5th, 1930, at Oshawa, to Mr. and Mrs. Harvey Harland (Dorothy Spears, General Hospital, Oshawa, 1926), a daughter (Frances Isobel).

HEAKES—On April 17th, 1930, at Toronto, to Mr. and Mrs. H. H. Heakes (Mary McKay, Toronto General Hospital, 1915), a son.

LEES—On April 24th, 1930, at Toronto, to Mr. and Mrs. J. Lees (Wyons Gillespie, Toronto General Hospital, 1927), a son.

LEWIS—On April 9th, 1930, at Regina, to Mr. and Mrs. Grant Lewis, a daughter.

LUKEC—Recently to Mr. and Mrs. E. Lukec (Cora Hazard, General Hospital, Moose Jaw, 1925), a daughter.

McELCHERAN—On March 21st, 1930, at Hamilton, Ont., to Mr. and Mrs. E. G. McElcheran (Myrtle Hodd, Toronto Western Hospital, 1922), twin girls.

McNALLY—On April 24th, 1930, to Mr. and Mrs. P. McNally (Cecelia O'Brien, Providence Hospital, Moose Jaw), a son.

PRITCHARD—On April 15th, 1930, at Toronto, to Mr. and Mrs. Pritchard (Leila Ham, Toronto General Hospital, 1923), twin sons.

WRINCH—On February 7th, 1930, at Montreal, to Mr. and Mrs. Sidney Wrinch (Jean Tier, Toronto Western Hospital, 1925), a daughter.

MARRIAGES

BARRY—JOHNSTON—In July, 1929, at New York, N.Y., Margaret Johnston (Toronto Western Hospital, 1921), to W. W. Barry, Long Island City, N.Y. At home—3253 23rd Street, Long Island City.

ELLIOTT—GOULD—On April 5th, 1930, at Toronto, Miriam G. Gould (Woodstock General Hospital), to W. J. Elliott, Windsor, Ont.

FLECK—BYRONS—On April 19th, 1930, Norma Byrons (Toronto General Hospital, 1928), to Douglas Fleck, of Toronto.

FRANKLIN—COWAN—On April 25th, 1930, at Chilliwack, B.C., Marion Cowan (Vancouver General Hospital), to Dr. B. H. Franklin, of Vancouver.

HALLER—LEE—On April 19th, 1930, at Bradford, Ont., Mina Jean Lee (Toronto Western Hospital, 1924), to Paul M. Haller.

MANSON—CURRIE—On April 30th, 1930, at Edmonton, Alta., Ina V. Currie (Montreal General Hospital), to Dr. Arthur B. Manson, of Vancouver, B.C.

McCORKINDALE — MARR — On April 17th, 1930, Jean Marr (Vancouver General Hospital), to R. Allan McCorkindale, of Seattle, Wash.

PARKINSON—HUNTER—On April 5th, 1930, at Toronto, Jean Ferguson Hunter (Toronto Western Hospital, 1927), to Joseph Parkinson, Toronto.

SIMMS—ANDERSON—Recently Dorothy Kate Anderson (Winnipeg General Hospital and lately of the staff, Vancouver General Hospital), to A. Ernest Simms, of Vancouver.

WRIGHT—WHITEFORD—On April 10th. 1930, Jessie Whiteford (Vancouver General Hospital), to Jesse Wright, of Vancouver.

DEATH

HARWOOD—On March 20th, 1930, at Moose Jaw, Sask., Mrs. F. C. Harwood (nee Jennie Galbraith, Prospect Heights Hospital, Brooklyn, N.Y.), wife of Dr. F. C. Harwood.

(Continued from page 316)

(9) Perhaps the weakest link in medical relationships is found in prenatal work. This can be strengthened by close co-operation with the family doctor, by reporting all new cases to him and requesting his permission for subsequent visiting.

(10) In child welfare centres where nurses prescribe feedings, sooner or later trouble always occurs. In home visiting, especially in infant welfare work, there is occasionally a desire not to support a doctor one hundred per cent. Disaster always follows the non-observance of professional etiquette and end results have always to be considered.

Doubtless there are many other equally as important points, but these may help to start discussion.

In concluding, it does not seem unnecessary repetition to re-emphasize the importance of a good, sane relationship between the visiting nurse and the medical profession. The nurse has a great responsibility in stimulating and strengthening such a relationship, and if she has sufficient vision to realise and appreciate such a service her contribution to public health work should be invaluable.

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A.A., CORNWALL GENERAL HOSPITAL

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A.A., ROYAL ALEXANDRA HOSPITAL, FERGUS

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A A., ST. JOSEPH'S HOSPITAL, HAMILTON,

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A.A., HOTEL DIEU, KINGSTON, ONT.

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A.A., KINGSTON GENERAL HOSPITAL

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A.A., VICTORIA HOSPITAL, LONDON, ONT.

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A.A., NIAGARA FALLS GENERAL HOSPITAL

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A.A., ORILLIA SOLDIERS' MEMORIAL HOSPITAL

Hon. President, Miss E. Johnston; President, Miss G. Went; First Vice-President, Miss M. Payne; Second Vice-President, Miss S. Dudenhoffer; Secretary-Treasurer, Miss M. B. MacLelland; Programme Committee, Misses C. Newton, A. Reekie, E. Mitchell and B. McFadden.

Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

Hon. President, Miss MacWilliams; President, Miss Ann Scott, 108 Division St., Oshawa; Vice-President, Mrs. E. Hare; Second Vice-President, Miss Olive Hanna; Secretary, Miss Elma Hogarth, 301 Celina St., Oshawa; Asst. Secretary, Mrs. Douglas Redpath; Corresponding Secretary and Press Representative, Miss Robena Buchanan, 564 Mary St., Oshawa; Treasurer, Miss Jane Cole; Social Convener, Miss Ruby Berry; Visiting and Flower Convener, Miss Helen Hutchison; Convener, Private Duty Nurses, Miss Margaret Dickie; Representative, Hospital Auxillary, Mrs. B. A. Brown, Mrs. M. Canning, and Mrs. E. Hare.

A.A., ST. LUKE'S HOSPITAL, OTTAWA

Hon. President, Miss Maxwell; President, Miss Doris Thompson; Vice-President, Miss Diana Brown; Secretary, Miss Isobel Allan, 408 Slater Street, Ottawa; Treasurer, Mrs. Florence Ellis; Nominating Committee, Misses Mina MacLaren, Hazel Lyttle, Katherine Tribble.

A.A., LADY STANLEY INSTITUTE, OTTAWA

(Incorporated 1918)

Hon. President, Miss M. A. Catton, 2 Regent St.; Hon. Vice-President, Miss Florence Potts; President, Miss Mabel M. Stewart, Royal Ottawa Sanatorium; Vice-President, Miss M. McNiece, Perley Home, Aylmer Ave.; Secretary, Mrs. G. O. Skuce, Britannia Bay, Ont.; Treasurer, Miss C. Slinn, 204 Stanley Ave.; Board of Directors, Miss E. MacGibbon, 114 Carling Ave.; Miss C. Flack, 152 First Ave.; Miss E. McColl, Vimy Apts., Charlotte St.; Miss L. Belford, Perley Home, Aylmer Ave.; "Canadian Nurse" Representative Miss A. Ebbs, 80 Hamilton Ave.; Representatives to Central Registry Nurses, Miss A. Ebbs, 80 Hamilton Ave.; Miss Mary C. Slinn, 204 Stanley Ave.; Press Representative, Mrs. J. Waddell, 220 Waverley St.

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A.A., OTTAWA GENERAL HOSPITAL

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A.A., TORONTO ORTHOPEDIC HOSPITAL TRAINING SCHOOL FOR NURSES

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A. A., HOSPITAL FOR SICK CHILDREN, TORONTO

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A.A., VICTORIA MEMORIAL HOSPITAL, TORONTO

Hon. President, Mrs. Forbes Godfrey; President, Miss Annie Pringle; Vice-President, Miss Dorothy Greer; Secretary, Miss Florence Lowe, 152 Kenilworth Ave., Toronto; Treasurer, Miss Ida Hawley, 41 Gloucester St., Toronto.

Regular Meeting—First Monday of each month.

A.A., WELLESLEY HOSPITAL, TORONTO

President, Miss Edith Carson, 499 Sherbourne St.; Vice-President, Miss Ruth Jackson, 80 Summerhill Ave.; Treasurer, Miss Lucille Thompson, 4, 118 Isabella St.; Recording Secretary, Miss Mildred McMullen, 133 Isabella St.; Corresponding Secretary, Miss Evelyn McCullough, 1117 Danforth Ave.; Eexeutive, Misses Edna Tucker, Betty Scott, Doris Anderson, Audrey Lavelle; Correspondent to The Canadian Nurse, Miss Waple Greaves, 65 Glendale Ave.

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses' Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

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A.A. CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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A.A., LACHINE GENERAL HOSPITAL

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Meeting—First Monday of each month, at 9 p.m.

MONTREAL GRADUATE NURSES' ASS'N.

Hon. President, Miss L. Phillips, 3626 St. Urbain St.; President, Miss A. Kinder, Children's Memorial Hospital; First Vice-President, Miss C. Ferguson, Alexandra Hospital; Second Vice-President, Miss C. M. Watling, 1230 Bishop Street; Secretary-Treasurer, Miss E. Mackay, 1230 Bishop Street; Day Registrar, Miss L. White, 1230 Bishop St.; Night Registrar, Miss E. Clarke, 1230 Bishop St.; Convener, Griffintown Club, Miss G. Colley, 261 Melville Avenue, Westmount, P.Q.

Regular Meeting—First Tuesday, January, April, October, and December.

A.A., CHILDREN'S MEMORIAL HOSPITAL, MONTREAL

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A.A., MONTREAL GENERAL HOSPITAL

President, Miss M. K. Holt; First Vice-President, Miss Frances Upton; Second Vice-President, Miss Agnes Jamieson; Recording Secretary, Miss Inez Welling; Corresponding Secretary, Miss Lottie Urquhart, Apt. 53, 8 Amesbury Ave.; Treasurer, Alumnae Association and Mutual Benefit Association, Miss Isobel Davies; Hon. Treasurer, Miss H. M. Dunlop; Executive Committee, Misses Strumm, Handcock, Watling, Mathewson and Coleman; Representatives, Private Duty Section, Misses Morrell, M. N. Johnston and B. Noble; Representative, Local Council of Women, Misses Colley and Marjorie Ross; proxy, Miss Harriet Ross; Representative to The Canadian Nurse, Miss Watling, Miss E. Ward; Sick Visiting Committee, Mrs. Stuart Ramsay, Miss E. Robertson, Miss N. Kennedy-Reed; Refreshments Committee, Miss Reinauer and Miss D. Flint.

A.A., HOMOEOPATHIC HOSPITAL, MONTREAL

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A.A., ROYAL VICTORIA HOSPITAL, MONTREAL

Hon. Presidents, Misses Draper and Hersey; President, Mrs. Stanley; First Vice-President, Mrs. LeBeau; Second Vice-President, Miss Gall; Recording Secretary, Miss Grace Martin; Corresponding Secretary, Miss K. Jamer, Royal Victoria Hospital; Treasurer, Miss Burdon; Representative "The Canadian Nurse," Miss Flanagan; Representatives to Local Council of Women, Mrs. Walker, Miss Drake; Sick Visiting Committee, Miss Allder, Mrs. Walker; Programme Committee, Mrs. Scrimger, Miss Campbell, Miss Flanagan; Representatives to Private Duty Section, Misses Palliser, McCallum, Steele; Refreshment Committee, Misses Adams, McRae, Trenholme; Executive Committee, Miss Hersey, Miss Campbell, Mrs. Roberts, Miss Reid, Miss Forgey; Finance Committee, Misses Etter (Convener), Goodhue, McKibbon, Wright, Steele.

A.A., WESTERN HOSPITAL, MONTREAL

Hon. President, Miss Craig; President, Miss Marion Nash; First Vice-President, Miss Birch; Second Vice-President, Miss Edna Payne; Secretary, Miss Olga McCrudden, 314 Grosvenor Ave., Westmount, P.Q.; Treasurer, Miss Jane Craig, Western Hospital; Finance Committee, Miss MacWhirter, Miss Lillian Payne, Miss Sutton; Programme Committee, Miss Marjorie Reyner, Miss Crossley, Miss Lilly; Sick and Visiting Committee, Miss Dyer, Miss Lillian Johnston; Representatives to Private Duty Section, Miss Tyrell, Miss Morrison; Correspondent, The Canadian Nurse, Miss McOuat.

A.A., NOTRE DAME HOSPITAL, MONTREAL

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A.A., WOMEN'S GENERAL HOSPITAL, WESTMOUNT, P.Q.

Hon. Presidents, Miss E. F. Trench and Miss F. George; President, Miss L. Smiley; First Vice-President, Mrs. Crewe; Second Vice-President, Mrs. Robertson; Secretary, Miss Craymer; Treasurer and "The Canadian Nurse" Representative, Miss E. L. Francis; Sick Visiting, Mrs. Kirk, Miss N. J. Brown; Private Duty, Mrs. Chisholm, Miss Seguin.

Regular monthly meeting, every third Wednesday, at 8 p.m.

A.A. JEFFERY HALE'S HOSPITAL, QUEBEC

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A.A., SHERBROOKE HOSPITAL

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A.A., REGINA GENERAL HOSPITAL

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A.A. ST. PAUL'S HOSPITAL, SASKATOON

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Meetings, second Monday each month at 8.30 p.m., St. Paul's Nurses Home.

A.A., SCHOOL FOR GRADUATE NURSES, McGILL UNIVERSITY, MONTREAL, P.Q.

Hon. President, Miss Mary Samuel; Hon. Vice-President, Miss Bertha Harmer; Hon. Members, Miss M. F. Hersey, Miss G. M. Fairley, Dr. Helen R. Y. Reid, Dr. Maude Abbott, Mrs. R. W. Reford; President, Miss Louise M. Dickson, Shriners' Hospital, Montreal; Vice-President, Miss Olga Lilly, Royal Victoria Maternity Hospital; Secretary-Treasurer, Miss Dorothy P. Cotton, 1227 Sherbrooke St. W.; Programme Committee, Miss M. Armstrong, 1230 Bishop St.; Representative to Local Council of Women, Miss M. Dobie, Royal Victoria Hospital; Representatives to The Canadian Nurse, Administration, Miss F. Upton; Public Health, Miss Lecompte; Teaching, Miss E. Hillyard, Children's Memorial Hospital, Montreal.

A.A. OF THE DEPT. OF PUBLIC HEALTH NURSING, UNIVERSITY OF TORONTO

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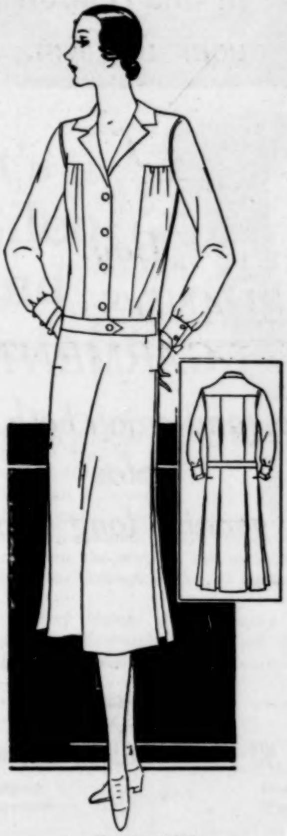

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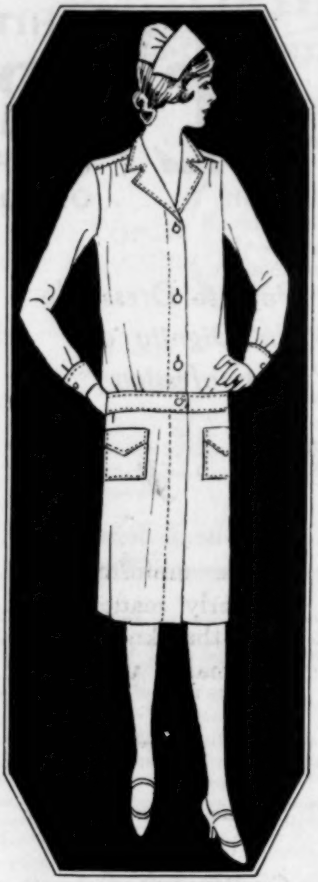

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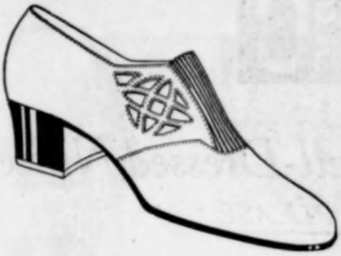

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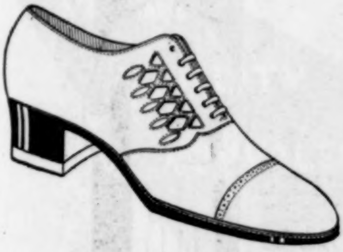

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